CCME

2021 External Quality Review

SELECT HEALTH OF SOUTH CAROLINA

Submitted: December 17, 2021

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

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process for, and the results of, the 2021 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Select Health Of South Carolina (Select Health) since the 2020 Annual Review.

The goals and objectives of the review are to:

- Determine if Select Health is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2020 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate that contracted health care services are being delivered and of good quality.

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

Summary and Overall Findings

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

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess Select Health's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration:

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

Select Health has established policies and procedures to guide staff in daily business operations. Policies are reviewed by department leaders with follow-up review and approval by the Policy and Procedure Subcommittee on an annual basis or more frequently as needed. Staff are informed of policy revisions.

The Organizational Chart outlines staffing for all key positions by SCDHHS. Recruiting is currently in progress for 15 vacant Customer Services positions.

Select Health's Information Systems Capabilities Assessment (ISCA) documentation indicates the organization can satisfy the requirements of the *SCDHHS Contract*. The claim processing system is updated at least yearly, and a detailed patch management policy is in place to ensure other systems remain current. Select Health's data retention policy provides staff with an easy-to-understand retention schedule for the various documents they may handle. The organization's disaster recovery plans include failover to a stand-by data center which allows it to recover from regional disasters.

Select Health has an established Compliance Plan that addresses methods and process for detecting, preventing, and controlling fraud, waste, and abuse (FWA) and ensuring compliance with State and Federal regulations. A code of conduct guides staff in appropriate, ethical business behavior.

The Compliance Committee meets quarterly, and membership includes the Compliance Officer and other executive officials. Compliance training for all staff is conducted upon hire and annually.

Policies and procedures are in place to inform staff about the appropriate use and disclosure of Protected Health Information pursuant to the Health Insurance Portability (HIPAA) and other laws and regulations.

Provider Services:

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

Processes and requirements for credentialing and recredentialing activities are documented in policies. Credentialing and recredentialing files were well-organized and, after Select Health supplied additional information about the entity contracted to conduct exclusion and sanction queries, contained all required information. During the previous EQR, issues were noted related to queries of the Social Security Administration's Death Master File and verification of Clinical Laboratory Improvement Amendments (CLIA) certification; however, the current review confirmed these issues have been corrected.

The Credentialing Committee Charter defines the roles and responsibilities of the Credentialing Committee and describes the committee's membership. The membership of the Credentialing Committee includes practitioners with a variety of specialties, including Family Practice, Pediatrics, Psychiatry, Internal Medicine, and Surgery, but does not include mid-level practitioners as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*. Also, some members of the committee do not appear to meet the attendance expectation stated in the charter.

Select Health routinely monitors its network to ensure adequate member access to providers. Processes and practices for monitoring geographic network adequacy are included in policies, and the geographic access standards listed in the policies comply with contractual requirements. However, the policies did not include the access standards for occupational, physical, and speech/audiology therapy. Although not referenced in the policy, a review of submitted Geo Access reports confirmed access to these provider types is measured. Select Health's South Carolina Annual Assessment of Network Adequacy report indicates that for 2020, all requirements for time, distance, and member to provider ratios were met.

Appointment access standards are also documented in policy. For PCPs, the policy is missing requirements for wait times for scheduled routine appointments and appointment requirements for walk-in patients with non-urgent needs. Select Health assesses provider compliance with appointment access standards annually; however, when discussing a discrepancy in the appointment scheduling timeframe for non-urgent/regular PCP visits, Select Health confirmed that for the access call studies, they are assessing providers using a stricter standard than the standards listed in the policy and in the Provider Manual. This discrepancy between the policy and the South Carolina Accessibility of Services Report is a repeat finding from the previous EQR.

Results of the provider access study conducted by CCME revealed that the success rate significantly decreased from last year's rate and represented a statistically significant decline. This is also a repeat finding from the previous EQR.

Appropriate processes are in place for initial and ongoing provider education. The Provider Training and Education webpage on Select Health's website includes links for general provider training, cultural competency training, HEDIS® 101, and the Provider Portal Participant Guide. Current and previous updates are found on the Provider Alerts page of the website, and providers may sign up for emails containing important news and information. It was noted that the link in the Provider Manual for accessing the clinical practice guidelines takes the user to an incorrect webpage.

Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, list required medical record documentation elements; however, they do not include all required elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*. Documentation of Select Health's most recent annual medical record review confirmed that all required medical record documentation elements from the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)* were not included in the medical record review.

Member Services:

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

Policies and procedures are in place to address member rights and responsibilities. Information about member rights and responsibilities is available in the Member Handbook, Provider Manual, and on the website.

The Member Handbook provides information on preventive health services, case management programs, and instructions for obtaining educational support for medical, behavioral health, and pharmaceutical services. Select Health's website and mobile app are additional resources for members to obtain information about a variety of health topics. Processes are in place to inform members of, and encourage members to obtain, screenings and routine well visits.

CCME validated Member Satisfaction Surveys for both the Adult and Child populations. Select Health used an NCQA-certified vendor to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys. The surveys meet all requirements for validation; however, low response rates affect the generalizability of the surveys. CCME provided recommendations to increase future survey response rates.

Grievances

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

Grievance policies and procedures describe Select Health's processes for receiving, processing, and responding to member grievances. Grievance information is available in the Member Handbook, in the Provider Manual, and on the website. Timeframes for grievance acknowledgement, resolution, and extensions are outlined in policy, the Member Handbook, and on the website. Grievances are categorized and tracked, with a summary and analysis reported to the Quality of Service Committee annually. Of the grievance files selected for review, no issues were identified.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

Select Health has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided to all members. The QI program is managed at the health plan and no activities are delegated. The Quality Improvement Program Description 2021 is updated annually and submitted to the Quality Assessment Performance Improvement Committee and the Board of Directors for approval. The program description describes the quality improvement scope, goals, objectives, structure, and functions for the plan. Select Health provides information to members and providers about the QI Program via the Select Health website. The website contained information regarding the 2020 achievements and strengths, satisfaction survey results, 2021 program goals, and how a member or provider can obtain more information.

The AmeriHealth Caritas Board of Directors provides strategic direction for the QI program and retains ultimate responsibility and for ensuring the program is incorporated into the health plan's operation. The development, implementation, monitoring, and evaluation of the QI program is delegated to the Quality Assessment Performance Improvement Committee (QAPIC).

The QAPIC is chaired by the Market President. Voting members include seven practicing providers, one non-physician network provider, the Chief Medical Officer, several health plan medical directors, department directors, and managers. A quorum is established upon attendance of at least 50% of voting participants. Last year, CCME recommended recruiting additional network providers to serve on this committee due to poor attendance. The committee membership list and minutes showed several new providers were added.

Select Health develops a work plan annually that includes the deliverables, purpose or scope, frequency, and responsible party. The work plan is divided across three tabs and

focuses on five goals: access, clinical quality, satisfaction, qualified providers, and compliance. The annual work plan is initiated by the Quality Management department and forwarded to the QAPIC for review and recommendations.

Annually, Select Health evaluates the overall effectiveness of the QI Program and reports this assessment to the QAPIC. The 2020 Quality Improvement Program Evaluation included the results of all completed activities conducted in 2020. Results of the evaluation are used to develop recommendations for improvement and to propose goals and objectives for QI activities for the upcoming year. There were no issues identified with the program evaluation.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Select Health was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*. All relevant HEDIS performance measures for the current measure year (2020) as well as the previous measure year (2019) and the change from 2019 to 2020 are reported in the Quality Improvement section of this report.

The following table provides a summary of rates that had a substantial (>10%) change from last year to this year. There were four rates that had a substantial increase and five rates that had a substantial decrease.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	64.04%	74.31%	10.27%
Asthma Medication Ratio (amr)			
51-64 Years	47.15%	59.3%	12.15%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	25.35%	47.21%	21.86%
Total	25.30%	47.21%	21.91%
Substantial Decrease in Rate (>10% decrease)			
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	46.03%	56.93%	-10.90%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
Eye Exam (Retinal) Performed	55.42%	43.31%	-12.11%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	54.17%	32.65%	-21.52%
13-17 years - 7-Day Follow-Up	29.17%	16.33%	-12.84%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	50.30%	40.27%	-10.03%

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

For the current EQR, Select Health submitted two PIP documents for validation. All the PIPs scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions is also included.

Table 2: Comprehensive Diabetes PIP

Comprehensive Diabetes Care Outcomes Measures	
The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8). The Comprehensive Diabetes Care control measure A1c slightly improved while the BP measure continued to trend negatively in 2020. Both measures were impacted by the COVID-19 pandemic and did not meet the plan's goal for the 75th percentile. A1c <8 measure showed a 3.56% increase from the previous year and met the plan's goal of a 2% increase. The slight improvement in the A1c <8 measure may be a result of increase in data exchange and increase use of the Category-ll codes. The plan has implemented a flat file data exchange with supplemental reports for providers and increased overall EMR remote access to effectuate a year-round medical record review program. The blood pressure control measure demonstrated an 8.04% decline and did not meet the goal. The member incentives continued and resulted in a less than 1% return rate and therefore did not indicate an improvement. The results of this PIP would indicate that the incentive intervention was not effective. However, with the other confounding factors affecting the rates cannot be made and interventions will be continued in 2021.	
Previous Validation Score	**Current Validation Score**
84/85=99% High Confidence in Reported Results	90/91= 99% High Confidence in Reported Results

Comprehensive Diabetes Care Outcomes Measures
Interventions
• Fall/Winter 2020 Newsletter Article: "How the A1c test can help you manage diabetes". • HbA1c testing gift card incentive voucher mailed to 466 members. • Implemented a flat file data exchange with supplemental reports for providers. • Control measures added to value-based programs (i.e., PCP-QEP, FQHC-QEP, and large hospital systems). These programs were in development in 2018, expanded for 2019, and continue to expand in 2020. • Continued use of Category-II codes and exploring more options for data exchange with direct EMR access. • The plan is currently working with lab vendors for monthly data file exchanges. • Virtual provider training and quality meetings were conducted throughout the year. • Spring-2020 Newsletter Article: "What is medicine adherence?"

Table 3: Well-Care Visits PIP

Well-Care Visits for Children and Adolescents in Foster Care in South Carolina	
The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase the compliance with well-care visits for the children and adolescents in the foster care. During the pilot project, Select Health found there was no defined process point for sharing health, behavioral health, dental history or detail prior to placement and no process for sharing information between Select Health and SC Department of Social Services (SCDSS) while the child is in placement. Another significant finding of the Health Care Pilot and Case Process Review was that, despite the fact that virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) well-child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits. Two of three (66%) well-child visit measures demonstrated improvement from the CY2019 baseline year: Adolescent Well-Care Visit (awc) and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34). One of three (33%) well-child visit measures, Well-Child Visits in the First 15 Months of Life (w15) 6+ Visits, experienced a small decrease from the CY2019 baseline year. All three measures (awc, w15, and w34) experienced substantial improvements from CY2018 to CY2020 — 5.94 percentage points, 3.37 percentage points, and 9.43 percentage points, respectively. The wcv is a new measure for this PIP. Baseline rates were presented for 3-11 years, 12-17 years, 18-21 years, and total.	
Previous Validation Score	**Current Validation Score**
83/83=100% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Interventions	
• Data mapping corrections: Select Health, SCDSS, and SCDHHS will convene numerous times each year to assess the need to refresh, modify, update and/or adjust the operational process-flows illustrated within the data maps. • Foster Care Program Implementation. • Rounds: Select Health Medical Directors will coordinate with SCDSS to perform clinical rounds on members.	

Well-Care Visits for Children and Adolescents in Foster Care in South Carolina
• Establishment of a SCDSS and Select Health Operations Team (facilitated by SCDSS): Workgroups and subcommittees have been created to increase collaboration among all parties and to help support the operational needs of the new program. • Data Sharing/Exchange, Analysis and Reporting: The SCDSS nightly data feed rosters of children in care is sent to SCDHHS to certify Medicaid eligibility and then on to Select Health who can then begin providing comprehensive assessments, well-child care, needed follow-up services and care management as needed. Additionally, Select Health has begun to produce gap-in-care reports to track utilization and care gaps, care management rosters, and other necessary information for SCDSS managers and field staff. A formal data-sharing agreement was fully executed in 2020 and will be assessed frequently for completeness, utility, and modifications based on relevant needs and technical parameters. Ad hoc report requests are submitted by SCDSS and fulfilled by SHSC under the *SCDHHS 2018 MCO Contract* provisions. • Member & Provider Data Portal Access for SCDSS Staff: Select Health will create a special user type for SCDSS Staff to access and use the NaviNet Provider Portal. Use of this resource will allow SCDSS Staff the ability to access member-level data for Foster Care members only.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Utilization Management:

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

CCME's assessment of Select Health's Utilization Management (UM) Program encompasses the UM Program Description, Population Health Strategy document, program evaluations, policies, member and provider materials, the health plan's website, and approval, denial, appeal, and case management files. The UM Program Description describes collaboration between the UM Program and other programs within the UM Department. Policies and procedures define how services are implemented and provided to members.

Appropriate personnel conduct reviews of service authorization requests using InterQual criteria or other established criteria. Review of approval and denial files provided evidence that appropriate processes are followed, and no major issues were identified. Review of appeal files indicate staff consistently follow established processes for handling appeals. Care Management (CM) policies document care management processes and services provided. CM files indicated care gaps are identified and addressed consistently, and services are provided for various risk levels.

Overall, the weaknesses identified include documentation related to the number of external practicing PCPs and specialists participating on the QCCC and outdated appeals language in Policy MMS.100, Member Grievances and Appeals Process.

Delegation:

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

Policies and procedures address processes for contracting with and conducting oversight of delegated entities and include actions that may be taken in response to poor performance. Pre-delegation evaluations are conducted to determine potential delegates' abilities to perform the delegated functions, and a formal annual assessment is conducted for each delegate. Ongoing monitoring is conducted through routine delegate reporting. Delegation agreements are implemented with all delegates and specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations. Documentation of preassessment activities, annual oversight, and ongoing monitoring was provided for each of Select Health's delegates. No issues were identified in the current review of delegation.

During the previous (2020) EQR, it was noted that Select Health's Credentialing / Recredentialing file review monitoring tool did not include the verification of the Clinical Laboratory Improvement Amendment (CLIA) Certificate and the requirements for the nurse practitioners as required in Exhibit B of Policy CP 210.107. The current EQR confirmed these issues were appropriately addressed and tools include all required elements.

State Mandated Services:

42 CFR § Part 441, Subpart B

Provider compliance with providing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through member medical record documentation reviews and HEDIS reports of well-child visits. Select Health provides all core benefits specified by the *SCDHHS Contract*.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were four standards scored as "Partially Met" and four standards scored as "Not Met." Following the 2020 EQR, Select Health submitted a Quality Improvement Plan to address the deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on January 12, 2021. The following is a high-level summary of those deficiencies:

- Credentialing files were missing evidence of query of the Social Security Administration's Death Master File.

- Recredentialing files revealed issues with primary source verification of the providers' CLIA Certificates or Certificates of Waiver.
- The Select Health of South Carolina Accessibility of Services Report indicated specialty providers were measured using an appointment access timeframe of six to eight weeks for routine care. This was inconsistent with the timeframe listed in Policy NM 159.203. This was repeat finding from the previous year's EQR.
- No improvements were shown in the Telephonic Provider Access Study conducted by CCME. Calls were successfully answered 77% of the time (130 of 168 calls) when omitting calls answered by personal or general voicemail messaging services. The success rate slightly decreased from the previous year's rate of 81%.
- Policy MEM 129.107, New Member Orientation Calls, states new members are mailed a First Choice New Member Packet within 30 days of enrollment notification and a Member ID Card within 15 days. During the onsite teleconference, Select Health staff confirmed New Member Packets and ID cards are mailed within 14 days of receiving enrollment information.
- Policy MEM 129.124, Member Requested Print Material, page 3, indicates members will receive a copy of the Member Handbook upon enrollment. However, staff confirmed new members receive a New Member Packet with instructions to access the Member Handbook from the website. This issue was discussed in the previous EQR with a recommendation to correct it.
- Select Health applies the Complex Care Management Standards of Practice to the care management program. CCME was not able to identify how the plan provides coordinated health care for members that require Targeted Case Management (TCM) Services. During the onsite teleconference, staff confirmed the requirements for TCM services were unexpectedly not documented in a policy.
- Select Health provided a copy of the Credentialing/Recredentialing file review tool and the monitoring results for the delegated entities conducting the credentialing and recredentialing activities. The tools did not include the verification of the CLIA Certificate and the requirements for nurse practitioners as required in Exhibit B of Policy CP 210.107.
- A deficiency noted in the previous EQR related to documentation of network adequacy standards in annual reporting documents was noted again in the current EQR.

During the current EQR, CCME assessed the degree to which the health plan implemented actions to address these deficiencies and found the Quality Improvement Plan regarding the discrepancies in the PCP appointment access requirements when comparing Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, and the Select Health of South Carolina Accessibility of Services Report was

uncorrected. Additionally, Select Health showed no improvement in the Telephonic Provider Access Study conducted by CCME.

Conclusions

Overall, Select Health met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Select Health's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

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

Category	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	8	6	75%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	8	8	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	39	39	100%
• Confidentiality *(§ 438.224)*	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	20	20	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	2	2	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	11	11	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	14	14	100%

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

Discrepancies for how Select Health is measuring routine appointment access and the decline in the results of the Provider Telephone Access Study were the only areas not meeting all the requirements. *Table 5, Scoring Overview,* provides an overview of the scoring of the current annual review as compared to findings of the 2020 review. For 2021, 210 of 214 standards were scored as "Met." Two standards were scored as "Partially Met" and two standards received a "Not Met" score.

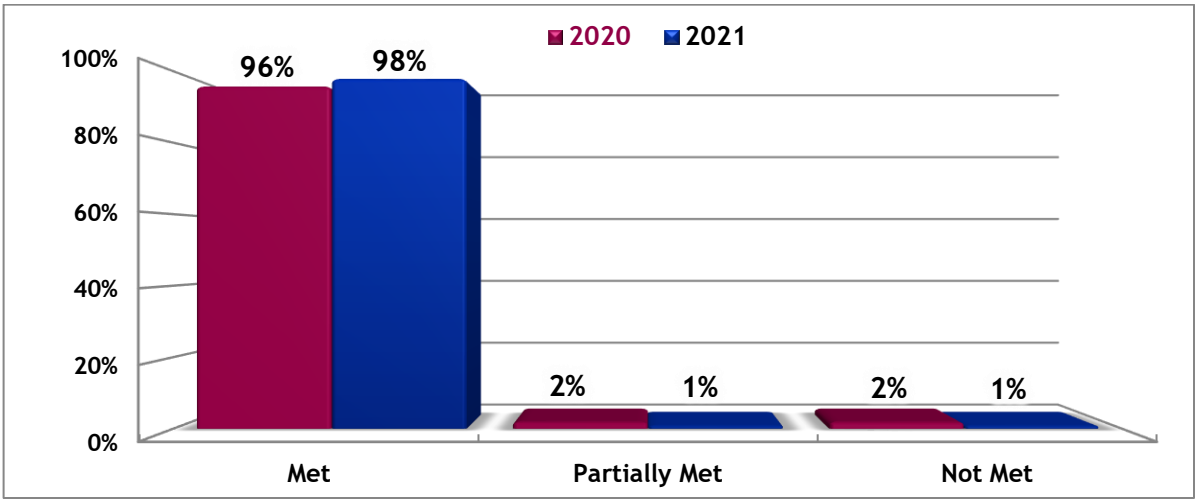
Table 5: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2020	40	0	0	0	0	40	100%
2021	40	0	0	0	0	40	100%
Provider Services							
2020	72	1	3	0	0	76	95%
2021	73	2	1	0	0	76	96%
Member Services							
2020	32	1	0	0	0	33	97%
2021	33	0	0	0	0	33	100%
Quality Improvement							
2020	14	0	0	0	0	14	100%
2021	14	0	0	0	0	14	100%
Utilization Management							
2020	44	1	0	0	0	45	98%
2021	45	0	0	0	0	45	100%
Delegation							
2020	1	1	0	0	0	2	50%
2021	2	0	0	0	0	2	100%
State Mandated Services							
2020	3	0	1	0	0	4	75%
2021	3	0	1	0	0	4	75%
Totals							
2020	**206**	**4**	**4**	**0**	**0**	**214**	**96.26%**
2021	**210**	**2**	**2**	**0**	**0**	**214**	**98.13%**

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

The 2021 Annual EQR shows that Select Health achieved a "Met" score for 98% of the standards reviewed. As the following chart indicates, 1% of the standards were scored as "Partially Met," and 1% of the standards scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2020 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Assessment of Strengths and Weaknesses

The following is a summary of Select Health's strengths, weaknesses, and recommendations or opportunities for improvement related to the quality, timeliness, and access to care identified during this annual review.

Table 6: Evaluation of Quality

Strengths Related to Quality
• Policy review and revision is initially conducted by departmental leadership. The Policy and Procedure Subcommittee meets monthly to review and approve policy changes. Staff are informed of policy revisions.
• Select Health has appropriate processes in place for maintenance, updates, and recovery of its data and information systems.
• Credentialing processes and requirements are documented in policy, and provider files reflect Select Health is conducting all required activities for initial credentialing and recredentialing.
• Select Health has been awarded the Multicultural Health Care Distinction by the National Committee for Quality Assurance six times, most recently in 2021.
• Select Health continues to offer provider training and education activities using alternate forums to ensure the safety of providers, provider staff, and health plan staff.
• Appropriate processes are in place for initial adoption, ongoing review and revision, and dissemination of preventive health and clinical practice guidelines to network providers.
• Select Health reviewed and revised Policy MEM 129.107, New Member Orientation Calls, to reflect New Member Packets and ID Cards processes and new member orientation.
• Select Health provides information to members and providers about the QI Program via the Select Health website. The website contained information regarding the 2020 achievements and strengths, satisfaction survey results, 2021 program goals and how a member or provider can obtain more information.
• Additional network providers were recruited to serve on the Quality Assessment Performance Improvement Committee.

Strengths Related to Quality

• The following HEDIS MY 2020 measure rates were strengths for Select Health since their rates had a greater than 10% improvement:
  ○ Asthma Medication Ratio (amr) for 51-64-year-olds improved 12.15% from last year
  ○ Pharmacotherapy for Opioid Use Disorder improved by almost 22%
  ○ For Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid improved 10.3%.
• All performance improvement projects scored within the High Confidence Range for the reported results.
• Select Health is conducting a COVID-19 project that includes outreach and education to all plan members.
• The Population Health Management Strategy document and the UM Program Description are well-written and appropriately describe the goals, scope, and structure of the programs.
• Policies and procedures detail processes and requirements for pre-delegation assessments, implementation of delegation agreements, annual oversight of delegate activities, and ongoing monitoring.
• Delegation agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.
• Documentation of preassessment activities, annual oversight, and ongoing monitoring for each of Select Health's delegates included deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• There were 15 vacant positions noted in the Customer Service area on the Organizational Chart.	• Recommendation: Monitor the current back-up plan to ensure that Customer Service responsibilities are met and review the recruitment process for the 15 vacant positions.
• For a total of 11 Credentialing Committee meetings from October 2020 through September 2021, two voting members did not meet the attendance expectation stated in the Credentialing Committee Charter. This was discussed during the onsite and Select Health staff stated that alternate practitioners may have attended the meeting in place of the absent practitioners; however, this was not apparent in the attendance documentation within the minutes.	• Recommendation: Reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectations. If alternate practitioners attend meetings in place of voting members, clearly notate this in the attendance documentation for the applicable meeting.
• Per the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, the Credentialing Committee should represent a broad network of representation from all disciplines including mid-level practitioners. No mid-level practitioners are included in the membership of Select Health's Credentialing Committee.	• Recommendation: Consider recruiting at least one mid-level practitioner for Credentialing Committee membership to comply with requirements in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.
• The Provider Manual, page 55, includes general information about clinical practice guidelines, and provides a link to providers to access the guidelines. However, the link takes the user to	• Recommendation: Update the Provider Manual to include the correct URL for the clinical practice guidelines.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
Select Health's Clinical Coverage Policies rather than to the clinical practice guidelines.	
• Policy QI 154.009, Medical Record Review, and its associated Attachment A, Medical Record Review Evaluation Form, list required medical record documentation elements but do not include all required elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*.	• Quality Improvement Plan: Revise Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, to include all medical record documentation elements required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O).*
• Documentation in the 2021 Annual Assessment of State Audits for Medical Record Documentation report indicates the medical record elements assessed during the medical record review (MRR), but these elements did not include all the required elements from the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*.	• Recommendation: Ensure the annual medical record review includes an assessment of provider compliance with all medical record documentation elements specified in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)* and noted in the Provider Manual.
• Select Health's annual medical record review (MRR) process is documented in Policy QI 154.009, Medical Record Review. The policy states that all PCP offices included in the MRR who score below the expected benchmark are notified of identified deficiencies, and a follow-up review will be conducted. However, the policy does not include the benchmark score.	• Recommendation: Revise Policy QI 154.009, Medical Record Review, to include the benchmark score for medical record reviews.
• The Quality of Clinical Care Committee Charter indicates that four external practicing PCPs and specialists are members of the committee, however the Committee List reflects three external providers.	• Recommendation: Consider amending the QCCC Charter to include Nurse Practitioners from the network to increase opportunities for provider participation.
• Page 13 of Policy MMS.100, Member Grievances and Appeals Process, has outdated language regarding requirements for a signed, written appeal to follow a verbal appeal.	• Recommendation: Ensure documents and materials are updated with current appeal filing procedures according to requirements in *42 CFR §438.402 (c)(3)* and the *SCDHHS Contract, Section 9.1.13.2*.
• There was no documented, quantitative improvement in processes or outcomes of care for the Comprehensive Diabetes Care Outcomes PIP.	• Recommendation: Continue interventions to improve rates by addressing patient and provider barriers. Determine if analysis should focus primarily on the BP control rate through the data sharing and MRR review interventions.
• Response rates for member satisfaction surveys decreased from the 2019 response rates and were below the NCQA target of 40%.	• Recommendation: Continue working with vendor to increase response, as they are below the NCQA target response rate of 40% and may affect the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.

Table 7: Evaluation of Timeliness

Strengths Related to Timeliness
• Timeframes for grievance acknowledgement, resolution, and extensions are correctly outlined in policy, the Member Handbook, and website. • Timeframe requirements for appeals resolutions were met.

Table 8: Evaluation of Access to Care

Strengths Related to Access to Care
• Options for reporting actual or suspected fraud, waste, and abuse are provided in various forums, including the Member Handbook, Provider Manual, and on the website. • Routine monitoring of network adequacy is conducted, and all required Status 1 providers are included in the Select Health provider network. • Online and printed Provider Directories are appropriately maintained and updated. Examination of the Provider Directories confirmed all required elements are included. • Select Health provided detailed information on current and future preventive health initiatives available to members in the 2021 EQR onsite presentation. • The Plan provides member assistance with filing appeal requests and other services upon request, such as interpreter services and materials translated in other languages. • Alerts in the provider portal, monthly emails, and provider education are examples of methods used to inform providers of members who are due for or have missed EPSDT visits.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Policy 159.206, Availability of Practitioners, does not address access parameters for occupational therapy, physical therapy, and speech/audiology therapy. A review of submitted Geo Access reports confirmed access to these provider types is measured.	• Recommendation: Revise Policy 159.206, Availability of Practitioners, to include the access requirements for occupational therapy, physical therapy, and speech/audiology therapy.
• Policy NM 159.308, Assessment of Physician Directory Accuracy, lists elements that must be included in the Provider Directory; however, it does not address the required elements of office hours, age groups, and website URLs.	• Recommendation: Update Policy NM 159.308, Assessment of Physician Directory Accuracy, to include the following required Provider Directory elements: office hours, age groups, and website URLs.
• Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, lists the appointment access standards for PCPs, but does not include the requirements for wait times for scheduled routine appointments or for walk-in patients with non-urgent needs. Refer to the *SCDHHS Contract, Section 6.2.2.3.*	• Recommendation: Revise Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, to include the requirements for wait times for scheduled routine appointments and for walk-in patients with non-urgent needs. Refer to the *SCDHHS Contract, Section 6.2.2.3.*

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Page three of the Select Health of South Carolina Accessibility of Services report for 2021 indicates the access standard for regular/routine PCP appointments is 10 business days, where policy NM 159.203 lists the timeframe as 4-6 weeks, as stated in the *SCDHHS Contract, Section 6.2.2.3*. Select Health confirmed the 10 business day timeframe was used for the appointment access survey. However, the Provider Manual, page 51, instructs that PCPs must adhere to a four week standard for routine visits; therefore, Select Health is assessing providers against a stricter standard than the routine PCP appointment standard documented in the Provider Manual.	• Quality Improvement Plan: Ensure appointment access studies are conducted using the parameters to which PCPs are instructed that they must comply.
• For the PCP telephonic provider access study conducted by CCME, calls were successfully answered 56% of the time. This success rate is a significant decrease from last year's rate of 77% and is a statistically significant decline (p <.001).	• Quality Improvement Plan: To improve results of Provider Access Studies, determine barriers to updating provider status as active. Continue to review records to ensure provider contact information is updated and initiate new interventions to update provider information.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for external quality review of Medicaid Managed Care Organizations and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On September 13, 2021, CCME sent notification to Select Health that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for desk review and an invitation for a teleconference to allow Select Health to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Select Health on September 27, 2021, and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on November 17, 2021, and November 18, 2021. The onsite visit focused on areas not covered in the desk review or for which clarification was needed. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference; interviews with Select Health's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between Select Health and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

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

The review of the Administration section includes policy management, staffing, information systems, compliance processes, and confidentiality.

Policies and procedures are in place to guide staff in the daily operation of the health plan. Policies are reviewed annually by department leaders with follow-up review and approval by the Policy and Procedure Subcommittee. Additional policy review and revision is conducted when changes in state for federal requirements necessitate.

All key staffing positions are filled, as indicated by the Organizational Chart. Select Health has sufficient staffing in place to conduct business operations; however, there were 15 vacant positions in the Customer Services area. The Plan confirmed during onsite discussion that recruiting efforts are underway to fill the vacant positions.

Select Health's ISCA documentation indicates the organization can satisfy the requirements of the *SCDHHS Contract*. The claim processing system is updated at least yearly, and a detailed patch management policy is in place to ensure other systems remain current. Select Health's data retention policy provides staff with an easy-to-understand retention schedule for the various documents they may handle. Disaster recovery plans include failover to a stand-by data center, which allows it to recover from regional disasters.

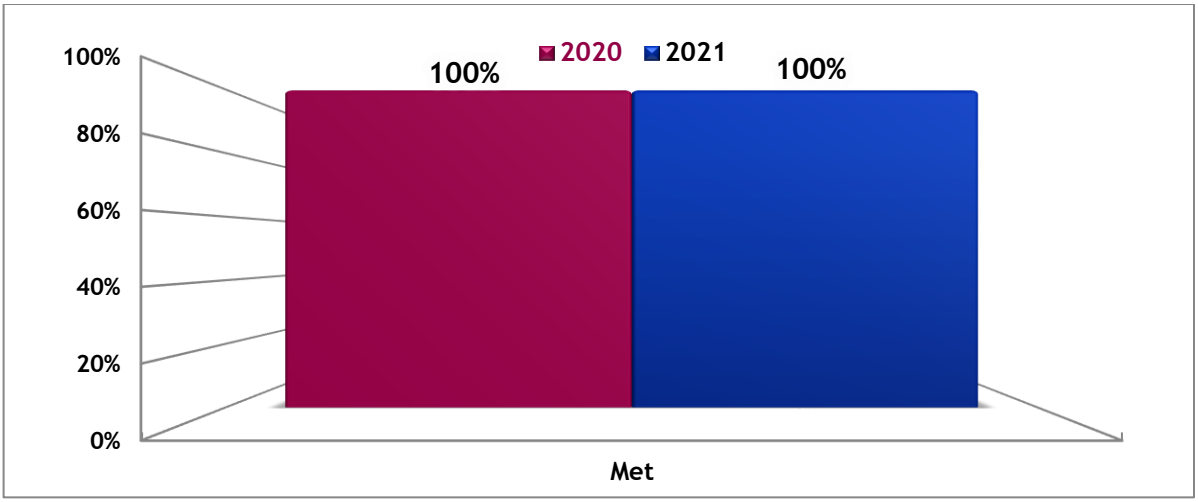
Select Health has an established Compliance Plan to guide staff in the detection, prevention, and response to fraud, waste, and abuse (FWA), and to ensure compliance with State and Federal regulations. The Code of Conduct and Ethics and Disciplinary Action Plan provides staff with information about appropriate and ethical business behavior.

The Compliance Committee meets quarterly, and membership includes the Compliance Officer and other executive officials. Compliance training is mandatory, conducted upon hire and annually thereafter. AmeriHealth Caritas and Select Health require members of the Board of Directors, all associates, contingent workforce members, subcontractor-vendors, and first-tier, downstream, and related entities to receive training and education related to the Compliance Program.

Policy 168.101, Confidentiality, and the Select Health 2020/2021 Confidentiality, Privacy, and Security Agreement Statement indicate that all associates, during the course of business operations, have a responsibility for the use and disclosure of Protected Health Information pursuant to the Health Insurance Portability and Accountability Act and other applicable laws and regulations.

As noted in *Figure 2: Administration Findings*, 100% of the standards in the Administration section were scored as "Met."

Figure 2: Administration Findings



Strengths

- Policy review and revision is initially conducted by departmental leadership. The Policy and Procedure Subcommittee meets monthly to review and approve policy changes. Staff are informed of policy revisions.
- Select Health has appropriate processes in place for maintenance, updates, and recovery of its data and information systems.
- Options for reporting actual or suspected fraud, waste, and abuse are provided in various forums, including the Member Handbook, Provider Manual, and on the website.

Weaknesses

- There were 15 vacant positions noted in the Customer Service area on the Organizational Chart.

Recommendations:

- Monitor the current back-up plan to ensure that Customer Service responsibilities are met and review the recruitment process for the 15 vacant positions.

B. Provider Services

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

The review of Provider Services includes credentialing and recredentialing processes and files, network adequacy, provider accessibility, provider education, clinical practice and preventive health guidelines, continuity of care, and medical record documentation monitoring.

Provider Credentialing and Selection

Select Health's Credentialing Program 2021 (Credentialing Program Description) was last revised in September 2021 and includes the program's scope, criteria, goals, and structure, as well as information about confidentiality. Processes and requirements for credentialing and recredentialing activities for practitioners are documented Policy CR.100.SC, Health Care Professional Credentialing and Re-credentialing. The corresponding policy for organizational providers is Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process. Additional information about provider application management is found in Policy NM 159.201, Provider Application and Tracking Log.

The Credentialing Committee Charter defines the roles and responsibilities of the Credentialing Committee and describes the committee's membership. Voting members of the committee include practicing practitioners, with the Chairperson voting only to resolve a tie vote. The committee meets monthly, and the quorum is established as the presence of 51% of the voting members. The membership of the Credentialing Committee includes practitioners with a variety of specialties, including Family Practice, Pediatrics, Psychiatry, Internal Medicine, and Surgery. The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, states the committee will represent a broad network of representation from all disciplines including mid-level practitioners; however, no mid-level practitioners are included in the membership of Select Health's Credentialing Committee.

According to the Credentialing Committee Charter, members that attend less than 50% of the Credentialing Committee meetings are counseled by the chairperson and can be replaced if necessary. Review of Credentialing Committee meeting minutes for 11 meetings from October 2020 through September 2021 reflected two voting members did not meet the attendance expectation. During discussion of this finding, Select Health staff reported that alternate practitioners may have attended the meeting in place of the absent practitioners; however, this was not apparent in the attendance documentation in the minutes.

Credentialing and recredentialing files were well organized and most required information was included. CCME could not clearly identify evidence of queries of the Office of the Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE) and System for Award Management (SAM)—each of the files contained a dated printout labeled as "Exclusion Results from NPI Search" but these documents did not specify the actual queries conducted. This was discussed during the onsite, and Select Health reported they are contracted with ProviderTrust to conduct queries of state and federal sanctions, exclusions, and monitoring databases and sites. The agreement between Select Health and ProviderTrust was provided and confirmed all required queries are conducted.

Therefore, no issues were noted in the initial credentialing and recredentialing files for practitioners and organizational providers.

As noted in *Table 9: Previous Provider Credentialing and Selection QIP Items*, during the previous EQR, issues were noted related to queries of the Social Security Administration's Death Master File and verification of Clinical Laboratory Improvement Amendments (CLIA) certification. The current review confirmed these issues have been corrected.

Table 9: Previous Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
3.1 Verification of information on the applicant, including: 3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	One initial credentialing file was missing evidence of query of the Social Security Administration's Death Master File. Three additional initial credentialing files did not contain clear evidence that the query of the Social Security Administration's Death Master File was conducted against the provider's Social Security Number. *Quality Improvement Plan: Ensure all initial credentialing files contain evidence of querying the Social Security Administration's Death Master File and that the evidence clearly indicates the provider's Social Security Number was used for the query.*
Select's Response: The Credentialing Department received additional education on proper verification of SSDMF results by Social Security Number through Provider Trust. Associates will search the databases utilizing the providers Social Security Number and the results will be saved as a PDF in the provider's credentialing file. Please see updated Credentialing Team Training Bulletin-Provider Trust implemented in October 2020 for the Credentialing Team. As part of its monitoring and auditing plans, the health plan will complete a review of a sample of files on an ongoing basis to verify this process continues to be performed.	
4.2 Verification of information on the applicant, including: 4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	Policy CR.100.SC, Health Care Professional Credentialing and Re-credentialing, states Primary Source Verification (PSV) is completed on the Clinical Laboratory Improvement Amendment (CLIA) for any practitioner who has lab services in an office where they are treating members and who does not submit a current copy of the CLIA. The policy further states, "All verifications, with the exception of education/training and work history may not be older than 120 calendar days at the time of the credentialing or re-credentialing decision." Of 16 recredentialing files reviewed, 9 files revealed issues with primary source verification (PSV) of the providers' CLIA Certificates or Certificates of Waiver. The following issues were noted in these 9 files (note: some files contained more than one location for which CLIA would apply): •In two files, there was no evidence of PSV of the CLIA. •In two files, the PSV of the CLIA occurred after the recredentialing decision date.

Standard	EQR Comments
	•In six files, the PSV of the CLIA occurred more than 120 days prior to the recredentialing decision date. (Note: one was more than 12 months prior, and another was 21 months prior.) •In one file, the PSV of the CLIA was for a different address. *Quality Improvement Plan: Ensure primary source verification of CLIA Certificates or Certificates of Waiver are included in each recredentialing file, are conducted within the timeframe specified in Policy CR.100.SC, Health Care Professional Credentialing and Re-credentialing, and are for the correct location.*
Select's Response: CLIA Primary Source Verifications will be completed for all credentialing and re-credentialing applications following the timeframes specified in policy CR.100.SC. The CLIA verification process has been updated to be in line with the CMS website updates. Additional education was provided to staff. Please see CLIA Bulletin and CLIA Process. As part of its monitoring and auditing plans, the health plan will complete a review of a sample of files on an ongoing basis to verify this process is being performed in accordance with CR.100.SC.	

Availability of Services

Select Health routinely monitors its network to ensure adequate member access to primary care providers (PCPs), specialists, ancillary providers, and hospitals. Processes and practices for monitoring geographic network adequacy are included in Policy NM 159.206, Availability of Practitioners. Access standards for PCPs, specialists, etc. are documented in Policy NM 159.206, Availability of Practitioners, and are compliant with contractual requirements. This policy, however, did not include the access standards for occupational therapy, physical therapy, and speech/audiology therapy. Although not referenced in the policy, a review of submitted Geo Access reports confirmed access to these provider types is measured. Select Health's goal is to meet or exceed contractual geographic access standards by ensuring that 95% of members have access to providers within the required parameters. The Select Health of South Carolina Annual Assessment of Network Adequacy (Reporting Period: Annual 2020) indicates that for the 2020 reporting year, Select Health met all requirements for time, distance, and member to provider ratios for all practitioner types.

Appointment access standards for PCPs and specialists are included in Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey. For PCPs, the policy does not include the requirements for wait times for scheduled routine appointments or for walk-in patients with non-urgent needs. As noted in the policy, Select Health assesses provider compliance with appointment access standards annually. The Select Health of South Carolina Accessibility of Services report for 2021, page three, indicates the access standard for regular/routine PCP appointments is 10 business days, where policy NM 159.203 lists the timeframe as four to six weeks, as stated in the *SCDHHS Contract, Section 6.2.2.3*. After discussing this finding during the

onsite, Select Health provided additional information via email that the report was correct, and the survey was conducted using the 10 business day timeframe for routine PCP appointments. However, this is stricter than the routine PCP appointment standard documented in the Provider Manual, page 51, to which providers are informed that they must adhere.

As noted in *Table 10: Previous Availability of Services QIP Items*, during the previous EQR, Select Health had discrepancies in the timeframe for PCP appointment access when comparing the information in Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey and the Select Health of South Carolina Accessibility of Services Report. This was noted again a finding in the current EQR.

Table 10: Previous Availability of Services QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Select Health conducts an annual analysis of data to measure performance against standards for appointment access. Data includes findings from network accessibility reporting, member grievances and appeals, and CAHPS results. The objective is that 90% of the provider offices meet or exceed access standards. Additionally, an annual after-hours survey is conducted for all PCP locations. When gaps are identified, a comprehensive analysis, identifying barriers, opportunities, and appropriate interventions, is conducted. The Select Health of South Carolina Accessibility of Services Report indicates the goal of 90% was exceeded for after-hours access to primary care, PCP appointment access for routine and urgent care, and most categories for specialty appointment access. Categories for which the goal was not met included urban otolaryngology (high volume and high impact) and rural allergy (high volume). The report included barriers, opportunities for improvement, and interventions/action plans for improving access to care. However, the Select Health of South Carolina Accessibility of Services Report indicates specialty providers were measured using an appointment access timeframe of 6-8 weeks for routine care. This is inconsistent with the timeframe listed in Policy NM 159.203. This is repeat finding from the previous year's EQR. *Quality Improvement Plan: Revise the Select Health of South Carolina Accessibility of Services Report to reflect results of an analysis of appointment availability using the required standard of 4 to 12 weeks for routine specialty appointments. Refer to the SCDHHS Contract, Section 6.2.3.1.5.3.*

Standard	EQR Comments
Select's Response: Due to a typographical error, a correction has been made to the Accessibility of Services report. Routine Appointment Availability of Specialist was revised to 4 – 12 weeks. This time frame matches SCDHHS contractual requirement and Select Health of South Carolina Provider Network Management departmental policy. The revised report will be presented to the February 2021 QSC Committee. A copy of the proposed revisions to the Final Accessibility Report is included.	

Established processes are in place for ensuring the network can adequately meet the cultural, linguistic, and special accommodations needs of the membership population. The Cultural and Linguistically Appropriate Services (CLAS) Program promotes the delivery of services to people of all cultures, races, ethnic backgrounds, abilities, and religions. Select Health evaluates the effectiveness of the CLAS Program through internal audits, member satisfaction surveys, other outcomes-based evaluations, and performance improvement methodologies. In addition, the Select Health website includes information about the plan's commitment to cultural competency, health literacy, cultural competency training, etc. Links on the website take the user to external resources from various sources including the Office of Minority Health. Some of the resources provide CME credits for physicians and physician assistants or contact hours for nurse practitioners. It is noted that Select Health has earned the Multicultural Health Care (MHC) Distinction from the National Committee for Quality Assurance (NCQA) for a sixth time.

Provider Access and Availability Study

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

As part of the annual EQR process for Select Health, a provider access study focusing on primary care providers was conducted by CCME. Select Health submitted a list of current providers, from which a population of 2,780 unique PCPs was found. A sample of 190 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding access that members have with the contracted providers.

Calls were successfully answered 56% of the time (94 of 167) when omitting calls answered by personal or general voicemail messaging services (see Table 11 below).

Table 11: Telephonic Access Study Answer Rate Comparison

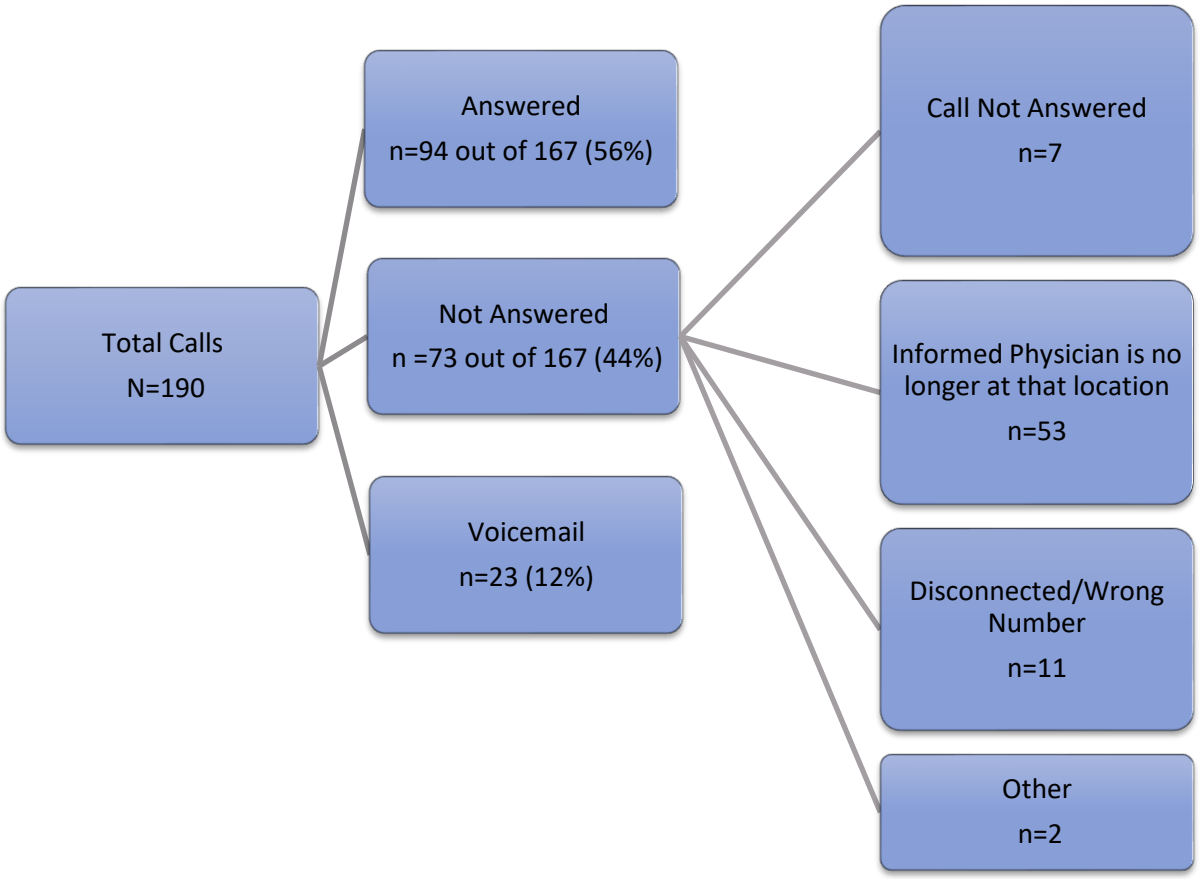
Review Year	Sample Size	Answer Rate	p-value
2020 Review	192	77% (130 out of 168)	<.001

Review Year	Sample Size	Answer Rate	p-value
2021 Review	190	56% (94 out of 167)	

When compared to last year's successful answer rate of 77%, this year's study rate of 56% was a statistically significant decrease in successful calls (p<.001). For those not answered successfully (n=73 calls), a majority of 53 (73%) were due to the physician no longer being active at that location.

Figure 3: Telephonic Provider Access Study Results provides an overview and breakdown of the findings of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



As noted in *Table 12: Previous Provider Access and Availability Study QIP Items*, during the previous EQR, Select Health showed no improvement in the Telephonic Provider

Access Study conducted by CCME. The current EQR revealed there was no improvement again this year.

Table 12: Previous Provider Access and Availability Study QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	As part of the annual EQR process for Select Health, a provider access study was conducted focusing on primary care providers. A list of current providers was given to CCME by Select Health, from which a population of 2,794 unique PCPs was found. A sample of 192 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the providers. During the Telephonic Provider Access Study conducted by CCME, calls were successfully answered 77% of the time (130 of 168 calls) when omitting calls answered by personal or general voicemail messaging services. The success rate slightly reduced from last year's rate of 81%. This is not a statistically significant decline (p = .520). *Quality Improvement Plan: Set a plan for provider network management workgroup to review records to ensure provider contact information is updated and initiate new interventions to update provider information.*
Select's Response: Provider Network Management (PNM) initiated a project/workgroup in February 2019 where the Account Executives review 30 provider records each month and confirmed with the provider office any updates and/or changes that are needed to their information. The project has been in place however due to COVID outreach efforts were complicated due to the state of emergency mandates on Providers. Effective January 2021, PNM will coordinate and lead the monthly meeting with Provider Network Operations Department and other necessary departments to review these results. The results from this workgroup will be presented to the Quality of Service Committee (QSC).	

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for initial and ongoing provider education are documented in Policy NM 159.102, Provider Orientation and Ongoing Training. Initial provider training is conducted within 30 calendar days of the provider being placed on active status. Orientation topics follow the Provider Manual. Ongoing training is conducted as necessary to ensure compliance with program standards. In addition, Select Health conducts annual regional training events. The Provider Training and Education webpage on Select Health's website includes links for general provider training, cultural competency training, HEDIS® 101,

and the Provider Portal Participant Guide. Current and previous updates are found on the Provider Alerts page of the website, and providers may choose to get emails containing important news and information.

Select Health adopts and conducts ongoing review of preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) that are based on the demographics and needs of the member population using criteria from nationally recognized professional organizations. Provider input about the guidelines is provided through the Clinical Policy Committee. The Provider Manual includes general information about guidelines and includes charts listing periodic health guidelines for children, adults, and obstetrical care. It was noted that the link in the Provider Manual for accessing the clinical practice guidelines takes the user to an incorrect webpage. Charts of adult and pediatric preventive health guidelines are found on the website, and additional information about adopted guidelines is found within the Provider Resources section of the website as well as through the provider portal.

Annually, the Quality Management Department monitors and trends continuity and coordination of care between PCPs and other providers. This is accomplished primarily through the medical record review process. Feedback is given to appropriate quality committees and individual practitioners, a summary report is presented to the QAPIC annually, and interventions are implemented when issues are identified.

Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, list required medical record documentation elements. However, the policy and the evaluation form do not include all required elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*. It was noted that the Provider Manual includes a much more comprehensive list of medical record documentation elements and informs that PCP medical records are monitored annually for compliance with the standards listed in the manual. Select Health's documentation indicates the most recent annual medical record review was completed in June 2021. The overall compliance rate was 99.75% (a slight increase from the 2020 rate). Opportunities and interventions were documented. The report confirmed that all the required elements listed in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)* were not included in the medical record review.

As noted in Figure 4: Provider Services Findings, 96% of the Provider Services standards were scored as "Met."

Figure 4: Provider Services Findings

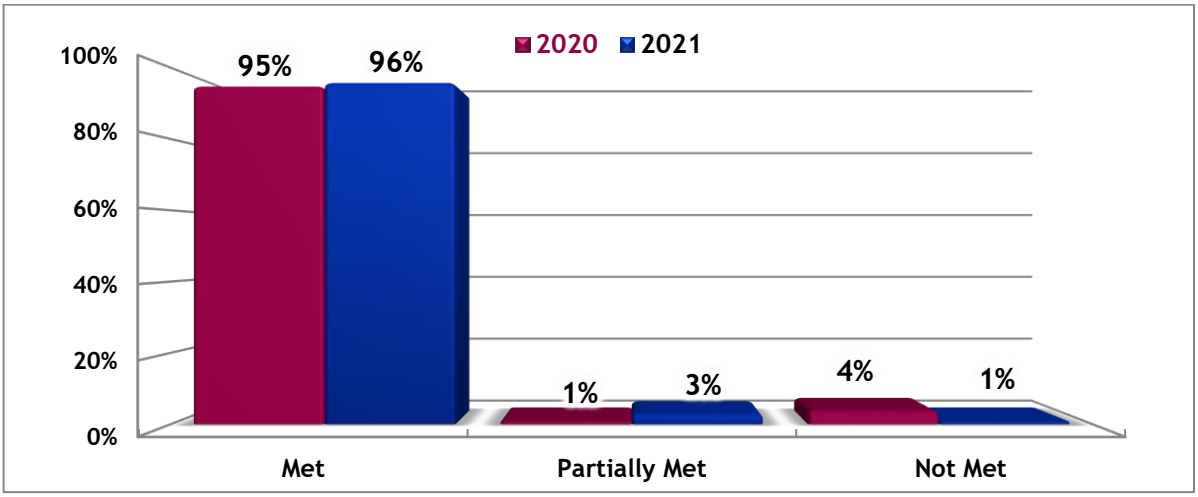


Table 13: Provider Services Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Credentialing and Recredentialing	The credentialing process includes verification of information on the applicant, including: Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	The recredentialing process includes verification of information on the applicant, including: Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Not Met	Met
Adequacy of the Provider Network	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Not Met	Partially Met
Practitioner Medical Records	Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- Credentialing processes and requirements are documented in policy, and provider files reflect Select Health is conducting all required activities for initial credentialing and recredentialing.
- Routine monitoring of network adequacy is conducted, and all required Status 1 providers are included in the Select Health provider network.
- Select Health has been awarded the Multicultural Health Care Distinction by the National Committee for Quality Assurance six times, most recently in 2021.
- Online and printed Provider Directories are appropriately maintained and updated. Examination of the Provider Directories confirmed all required elements are included.
- Select Health continues to offer provider training and education activities using alternate forums to ensure the safety of providers, provider staff, and health plan staff.
- Appropriate processes are in place for initial adoption, ongoing review and revision, and dissemination of preventive health and clinical practice guidelines to network providers.

Weaknesses

- For a total of 11 Credentialing Committee meetings from October 2020 through September 2021, two voting members did not meet the attendance expectation stated in the Credentialing Committee Charter. Select Health staff stated that alternate practitioners may have attended the meeting in place of the absent practitioners; however, this was not apparent in the attendance documentation within the minutes.
- Per the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, the Credentialing Committee should represent a broad network of representation from all disciplines including mid-level practitioners. No mid-level practitioners are included in the membership of Select Health's Credentialing Committee.
- Policy 159.206, Availability of Practitioners, does not address access parameters for occupational therapy, physical therapy, and speech/audiology therapy.
- Policy NM 159.308, Assessment of Physician Directory Accuracy, lists elements that must be included in the Provider Directory; however, it does not address the required elements of office hours, age groups, and website URLs.
- Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, lists the appointment access standards for PCPs, but does not include the requirements for wait times for scheduled routine appointments or for walk-in patients with non-urgent needs. Refer to the *SCDHHS Contract, Section 6.2.2.3*.

- Page three of the Select Health of South Carolina Accessibility of Services report for 2021 indicates the access standard for regular/routine PCP appointments is 10 business days, where policy NM 159.203 lists the timeframe as 4-6 weeks. Select Health confirmed the 10 business day timeframe was used for the appointment access survey. However, the Provider Manual, page 51, instructs that PCPs must adhere to a four week standard for routine visits; therefore, Select Health is assessing providers against a stricter standard than the routine PCP appointment standard documented in the Provider Manual, page 51, to which providers are informed that they must adhere.
- For the PCP telephonic provider access study conducted by CCME, calls were successfully answered 56% of the time. This success rate is a statistically significant decrease from last year's rate of 77%.
- The Provider Manual, page 55, includes general information about clinical practice guidelines, and provides a link to providers to access the guidelines. However, the link takes the user to Select Health's Clinical Coverage Policies rather than to the clinical practice guidelines.
- Policy QI 154.009, Medical Record Review, and its associated Attachment A, Medical Record Review Evaluation Form, list required medical record documentation elements but do not include all required elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*.
- Documentation in the 2021 Annual Assessment of State Audits for Medical Record Documentation report indicates the medical record elements assessed during the medical record review, but these elements did not include all the required elements from the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*.
- Select Health's annual medical record review process is documented in Policy QI 154.009, Medical Record Review. The policy states that all PCP offices included in the MRR who score below the expected benchmark are notified of identified deficiencies, and a follow-up review will be conducted. However, the policy does not include the benchmark score.

Quality Improvement Plans

- Ensure appointment access studies are conducted using the parameters to which PCPs are instructed that they must comply.
- To improve results of Provider Access Studies, determine barriers to updating provider status as active. Continue to review records to ensure provider contact information is updated and initiate new interventions to update provider information.
- Revise Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, to include all medical record documentation elements

required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*.

Recommendations

- Reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectations. If alternate practitioners attend meetings in place of voting members, clearly notate this in the attendance documentation for the applicable meeting.
- Consider recruiting at least one mid-level practitioner for Credentialing Committee membership to comply with requirements in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.
- Revise Policy 159.206, Availability of Practitioners, to include the access requirements for occupational therapy, physical therapy, and speech/audiology therapy.
- Update Policy NM 159.308, Assessment of Physician Directory Accuracy, to include the following required Provider Directory elements: office hours, age groups, and website URLs.
- Revise Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, to include the requirements for wait times for scheduled routine appointments and for walk-in patients with non-urgent needs. Refer to the *SCDHHS Contract, Section 6.2.2.3*.
- Update the Provider Manual to include the correct URL for the clinical practice guidelines.
- Ensure the annual medical record review includes an assessment of provider compliance with all medical record documentation elements specified in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)* and noted in the Provider Manual.
- Revise Policy QI 154.009, Medical Record Review, to include the benchmark score for medical record reviews.

C. Member Services

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

Policies and procedures are in place to address member rights and responsibilities. Information about member rights and responsibilities is included in the Member Handbook, Provider Manual, and on the Select Health website.

Policy MEM 129.107, New Member Orientation Calls, indicates Welcome Packets and member ID Cards are mailed within 14 days of enrollment. New member orientation calls are conducted to confirm that the Welcome Packet was received. Information on benefits, levels of care, and changes in benefits are provided in policy, the Member Handbook, and on the website. The Copay Reference Guide, that outlines applicable deductibles, copayments, limits of coverage, and maximum allowable benefits, is available to members via the website and by mail.

As noted in *Table 14: Previous Member MCO Program Education QIP Items*, Select Health was noted to have deficiencies in Policy MEM 129.107, New Member Orientation Calls. The current EQR confirmed the policy was corrected to reflect New Member Packets and ID Cards are mailed within 14 days of receiving enrollment, instead of incorrect timeframes that were previously documented.

Table 14: Previous Member MCO Program Education QIP Items

Standard	EQR Comments
III B. Member MCO Program Education	
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	Policy MEM 129.107, New Member Orientation Calls, states new members are mailed a First Choice New Member Packet within 30 days of enrollment notification and a Member ID Card within 15 days. During the onsite teleconference, Select Health staff confirmed New Member Packets and ID cards are mailed within 14 days of receiving enrollment information. The packet includes the Notice of Privacy Practices, Quick Start Guide, Personal Representative Form, and a welcome letter. Policy MEM 129.124, Member Requested Print Material, page 3, indicates members will receive a copy of the Member Handbook upon enrollment. However, staff confirmed new members receive a New Member Packet with instructions to access the Member Handbook from the website. This issue was discussed in the previous EQR with a recommendation to correct it. *Quality Improvement Plan: Correct Policy MEM 129.107, New Member Orientation Calls, to reflect New Member Packets and ID Cards are mailed within 14 days of receiving enrollment, instead of 30 days and 15 days, respectively. Refer to the requirement in the SCDHHS Contract, Section 3.14.3.*
Select Health: Policy MEM 129.107 was updated to state New Member packet is mailed within 14 days of receiving enrollment information. The proposed revisions will be submitted to the Policy and Procedure team in January 2021. A copy of the proposed revisions is included. Policy MEM 129.124 Member Requested Print Material, page 3, New Member Packet was updated on November 17, 2020. The revisions were in the definitions section of the policy. The definition of New	

Standard	EQR Comments
Member Packet was changed to mean the following: Package sent to new members upon enrollment within the plan. Contents include the Welcome Letter, Quick Start Guide, Personal Representative Form and Notice of Privacy Practices.	

The Member Handbook provides information on preventive health services, available case management programs, and instructions for obtaining educational support for medical, behavioral health, and pharmaceutical services. Select Health's website and mobile app have tools and information available on a variety of health topics. Additionally, the plan sends targeted mailers, such as brochure and newsletter, and makes calls to eligible members reminding them of screenings and well visits. Onsite discussion and the introductory presentation by Select Health provided detailed information on current and future preventive health initiatives available to members.

Member Satisfaction Survey Validation

Member Satisfaction Surveys for both the Adult and Child populations underwent validation by CCME using *EQR Protocol 6, Administration or Validation of Quality of Care Surveys*. Select Health contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems Survey vendor, to conduct the Adult and Child surveys.

The validations revealed sufficient sampling sizes; however, low response rates resulted in difficulty discerning the generalizability of the surveys. The response rates were as follows:

- Adult survey – response rate was 17% with a total of 279 of 1692 surveys completed
- Child Survey – response rate was 16.6% with a total of 317 of 2237 surveys completed
- Child with Chronic Conditions (CCC) – response rate was 17.2% with a total of 257 of 1607 surveys completed

All response rates decreased from 2019 and were below the NCQA target of 40%. However, the response rates for all three populations were above the SPH average rates.

The survey results are presented and discussed in appropriate committee meetings. The Child survey met goals for all but three measures: Getting Needed Care, Getting Care Quickly, and Coordination of Care. The other six measures did meet the 75th percentile goal, with Rating of Specialist showing the best percentile rank.

The Adult survey had some strong improvements in the Rating of the Health Plan and Getting Care Quickly. Seven measures were below the goal.

The Child with Chronic Conditions survey showed a strong increase in Rating of Specialist, and improvement in seven other measures; with goals not met for seven measures.

The complete validation results are detailed in *Attachment 3, EQR Validation Worksheet*.

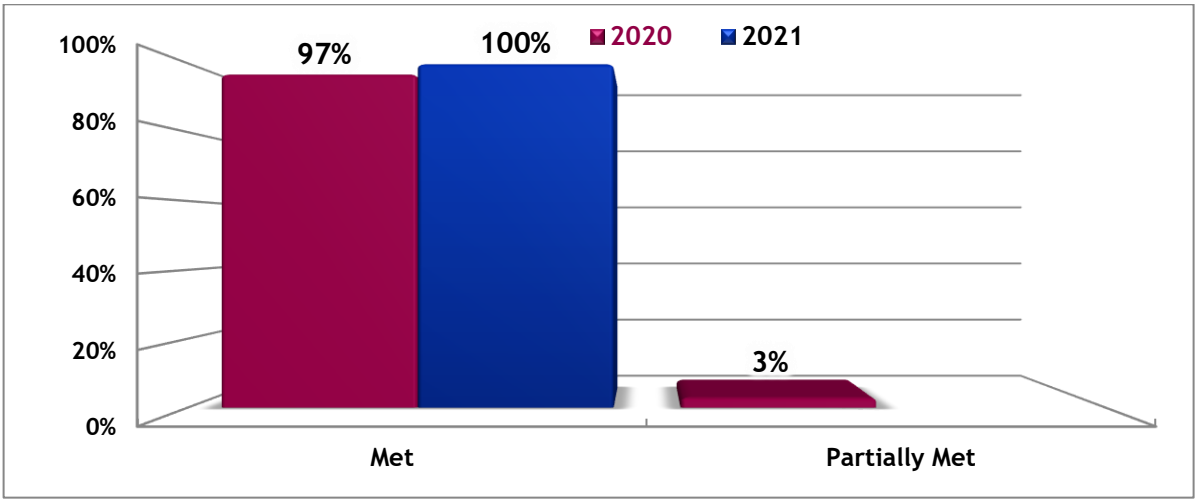
Grievances

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

Grievance policies and procedures describe Select Health's processes for receiving, processing, and responding to member grievances. Additionally, grievance information is provided via the Member Handbook, Provider Manual, and the website. Timelines for grievance acknowledgement and resolution, along with information about extensions of resolution timeframes, are correctly outlined in policy, the Member Handbook, and on the website. A summary of member grievance is reported to the Quality of Service Committee annually. Of the grievance files selected for review, it was determined that processes are applied as outlined in policy and as discussed onsite.

Figure 5: Member Services Findings, displays the scoring for the 2021 EQR for Member Services. 100% of the standards were scored as "Met."

Figure 5: Member Services Findings



Strengths

- Timeframes for grievance acknowledgement, resolution, and extensions are correctly outlined in policy, the Member Handbook, and website.
- Select Health provided detailed information on current and future preventive health initiatives available to members in the 2021 EQR onsite presentation.

Weakness:

- Response rates for member satisfaction surveys decreased from the 2019 response rates and were below the NCQA target of 40%.

Recommendation:

- Continue working with vendor to increase response, as they are below the NCQA target response rate of 40% and may affect the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.

D. Quality Improvement

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

Select Health has a Quality Improvement (QI) Program designed to monitor, evaluate, and improve the quality of care and services provided to all members. The QI program is managed at the health plan and no activities are delegated. The Quality Improvement Program Description 2021 is updated annually and submitted to the QAPIC and the Board of Directors for approval. The program description describes the quality improvement scope, goals, objectives, structure, and functions for the plan. Select Health provides information to members and providers about the QI Program via the Select Health website. The website contained information regarding the 2020 achievements and strengths, satisfaction survey results, 2021 program goals, and how a member or provider can obtain more information. One of the goals outlined in the QI Program Description is to reduce health care disparities. Annually, Select Health assesses the characteristics and needs of the member population, which includes children and adolescent members, members with disabilities, members with special needs, and members with serious and persistent mental illness. To further identify and reduce health care disparities, Select Health annually collects data on age, race ethnicity, gender, primary language, and disability status to identify and facilitate delivery of culturally competent health care and identify opportunities to reduce the disparities.

The AmeriHealth Caritas Board of Directors provides strategic direction for the QI program and retains ultimate responsibility for ensuring the program is incorporated into the health plan's operation. The development, implementation, monitoring, and evaluation of the QI program is delegated to the QAPIC. The QAPIC oversees Select Health's efforts to measure, manage, and improve the quality of care and services delivered to members as well as evaluate the effectiveness of the QI program. The primary responsibilities are included in the committee charter.

The QAPIC is chaired by the Market President. Voting members include seven practicing providers, one non-physician network provider, the Chief Medical Officer, several health

plan medical directors, department directors, and managers. A quorum is established upon attendance of at least 50 percent of voting participants. Last year, CCME recommended recruiting additional network providers to serve on this committee due to poor attendance. The committee membership list and minutes showed several new providers were added. Minutes are recorded for each meeting as evidenced by the committee minutes provided by Select Health. The minutes contained the meeting attendees, activities, decisions or recommendations, follow-up items, and responsible parties.

Select Health develops a work plan annually that includes the deliverables, purpose or scope, frequency, and responsible party. The work plan is divided across three tabs (QAPI, QCCC, and QSC) and focuses on five goals: access, clinical quality, satisfaction, qualified providers, and compliance. The annual work plan is initiated by the Quality Management department and forwarded to the QAPIC for review and recommendations.

Providers from Select Health's network are invited to participate as voting members on the QAPIC, the QCCC, and the Credentialing Committee. Providers are also informed in the Provider Manual of their expected cooperation with and participation in the QI program. The provider manual also encourages provider participation and includes contact information for participation. Primary care physicians receive report cards that provide direct feedback on the practitioner's performance on key quality measures compared to a peer group within Select Health's network. Member level data on key quality metrics and care gap reports are also available for network PCPs. The care gap reports display a member-specific care gap worksheet that identifies the care gap, along with a list of up-to-date services for the provider's reference.

Select Health evaluates the overall effectiveness of the QI Program and reports this assessment to the QAPIC. The 2020 Quality Improvement Program Evaluation included the results of all completed activities conducted in 2020. Results of the evaluation are used to develop recommendations for improvement and to propose goals and objectives for QI activities for the upcoming year. There were no issues identified with the program evaluation.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Select Health was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

All relevant HEDIS performance measures for the current review year (2020), as well as the previous year (2019) and the change from 2019 to 2020 are reported in *Table 15: HEDIS Performance Measure Results*. Changes in rates shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 15: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	79.90%	79.15%	-0.75%
Counseling for Nutrition	64.07%	69.1%	5.03%
Counseling for Physical Activity	59.30%	65.58%	6.28%
Childhood Immunization Status (cis)			
DTaP	77.62%	77.37%	-0.25%
IPV	92.46%	91.24%	-1.22%
MMR	88.56%	91%	2.44%
HiB	85.40%	87.35%	1.95%
Hepatitis B	91.97%	90.75%	-1.22%
VZV	88.32%	90.51%	2.19%
Pneumococcal Conjugate	82.97%	82%	-0.97%
Hepatitis A	84.43%	88.32%	3.89%
Rotavirus	78.59%	80.54%	1.95%
Influenza	38.69%	41.61%	2.92%
Combination #2	74.21%	74.21%	0.00%
Combination #3	72.51%	72.75%	0.24%
Combination #4	70.56%	72.51%	1.95%
Combination #5	63.50%	66.67%	3.17%
Combination #6	34.31%	37.47%	3.16%
Combination #7	62.53%	66.42%	3.89%
Combination #8	34.31%	37.47%	3.16%
Combination #9	31.39%	35.77%	4.38%
Combination #10	31.39%	35.77%	4.38%
Immunizations for Adolescents (ima)			
Meningococcal	76.40%	84.43%	8.03%
Tdap/Td	89.54%	91.97%	2.43%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	34.06%	40.39%	6.33%
Combination #1	75.43%	83.21%	7.78%
Combination #2	NR	38.69%	NA

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Lead Screening in Children (lsc)	76.32%	71.01%	-5.31%
Breast Cancer Screening (bcs)	60.56%	58.48%	-2.08%
Cervical Cancer Screening (ccs)	68.71%	66.39%	-2.32%
Chlamydia Screening in Women (chl)			
16-20 Years	58.16%	56.98%	-1.18%
21-24 Years	66.09%	64.21%	-1.88%
Total	59.98%	58.61%	-1.37%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	86.21%	85.85%	-0.36%
18-64 years	75.13%	74.03%	-1.10%
65+ years	NR	NA	NA
Total	84.49%	84%	-0.49%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	32.96%	30.96%	-2.00%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	64.04%	74.31%	10.27%
Bronchodilator	83.87%	86.9%	3.03%
Asthma Medication Ratio (amr)			
5-11 Years	74.10%	80.9%	6.80%
12-18 Years	64.19%	70.8%	6.61%
19-50 Years	56.11%	56.47%	0.36%
51-64 Years	47.15%	59.3%	12.15%
Total	67.28%	72.5%	5.22%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	60.10%	53.53%	-6.57%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	77.66%	79.1%	1.44%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	78.25%	82.06%	3.81%
Statin Adherence 80% - 21-75 years (Male)	60.70%	63.17%	2.47%
Received Statin Therapy - 40-75 years (Female)	76.90%	78.23%	1.33%
Statin Adherence 80% - 40-75 years (Female)	54.49%	63.48%	8.99%
Received Statin Therapy - Total	77.56%	80.07%	2.51%
Statin Adherence 80% - Total	57.55%	63.33%	5.78%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (18-64)	NR	3.67%	NA
Cardiac Rehabilitation - Engagement1 (18-64)	NR	2.86%	NA
Cardiac Rehabilitation - Engagement2 (18-64)	NR	2.04%	NA

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Cardiac Rehabilitation - Achievement (18-64)	NR	0.41%	NA
Cardiac Rehabilitation - Initiation (65+)	NR	NA*	NA
Cardiac Rehabilitation - Engagement1 (65+)	NR	NA*	NA
Cardiac Rehabilitation - Engagement2 (65+)	NR	NA*	NA
Cardiac Rehabilitation - Achievement (65+)	NR	NA*	NA
Cardiac Rehabilitation - Initiation (Total)	NR	3.67%	NA
Cardiac Rehabilitation - Engagement1 (Total)	NR	2.86%	NA
Cardiac Rehabilitation - Engagement2 (Total)	NR	2.04%	NA
Cardiac Rehabilitation - Achievement (Total)	NR	0.41%	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	89.35%	84.67%	-4.68%
HbA1c Poor Control (>9.0%)	46.03%	56.93%	-10.90%
HbA1c Control (<8.0%)	43.50%	36.98%	-6.52%
HbA1c Control (<7.0%)	29.20%	NR	NA
Eye Exam (Retinal) Performed	55.42%	43.31%	-12.11%
Medical Attention for Nephropathy	91.16%	NR	NA
Blood Pressure Control (<140/90 mm Hg)	60.29%	53.04%	-7.25%
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	NR	23.14%	NA
Kidney Health Evaluation for Patients With Diabetes (65-74)	NR	NA*	NA
Kidney Health Evaluation for Patients With Diabetes (75-85)	NR	NA*	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	NR	23.15%	NA
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	60.72%	62.34%	1.62%
Statin Adherence 80%	53.12%	56.7%	3.58%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	45.52%	47.21%	1.69%
Effective Continuation Phase Treatment	29.82%	30.9%	1.08%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	44.38%	45.3%	0.92%
Continuation and Maintenance Phase	56.88%	60.3%	3.42%
Follow-Up After Emergency Department Visit for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	74.62%	78.35%	3.73%
6-17 years - 7-Day Follow-Up	48.99%	53.87%	4.88%
18-64 years - 30-Day Follow-Up	57.21%	56.35%	-0.86%
18-64 years - 7-Day Follow-Up	33.41%	35.67%	2.26%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
65+ years - 30-Day Follow-Up	NR*	NR*	NA
65+ years - 7-Day Follow-Up	NR*	NR*	NA
30-Day Follow-Up	67.03%	69.01%	1.98%
7-Day Follow-Up	42.20%	46.14%	3.94%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	73.95%	73.18%	-0.77%
6-17 years - 7-Day Follow-Up	56.91%	58.52%	1.61%
18-64 years - 30-Day Follow-Up	51.31%	45.26%	-6.05%
18-64 years - 7-Day Follow-Up	36.27%	32.48%	-3.79%
65+ years - 30-Day Follow-Up	NR*	NR*	NA
65+ years - 7-Day Follow-Up	NR*	NR*	NA
30-Day Follow-Up	65.76%	60.84%	-4.92%
7-Day Follow-Up	49.45%	47.01%	-2.44%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	54.17%	32.65%	-21.52%
13-17 years - 7-Day Follow-Up	29.17%	16.33%	-12.84%
18-64 years - 30-Day Follow-Up	39.41%	41.92%	2.51%
18-64 years - 7-Day Follow-Up	28.82%	29.34%	0.52%
65+ years - 30-Day Follow-Up	NR*	NR*	NA *
65+ years - 7-Day Follow-Up	NR*	NR*	NA*
Total - 30-Day Follow-Up	40.38%	40.73%	0.35%
Total - 7-Day Follow-Up	28.85%	27.68%	-1.17%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	11.00%	8.18%	-2.82%
7-Day Follow-Up: 13-17 Years	3.00%	5.45%	2.45%
30-Day Follow-Up: 18+ Years	16.59%	18.14%	1.55%
7-Day Follow-Up: 18+ Years	12.26%	12.2%	-0.06%
30-Day Follow-Up: Total	15.86%	16.71%	0.85%
7-Day Follow-Up: Total	11.05%	11.23%	0.18%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	80.26%	74.26%	-6.00%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	71.11%	66.56%	-4.55%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	83.33%	66.67%	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	25.35%	47.21%	21.86%
65+ years	0%	NA*	NA*
Total	25.30%	47.21%	21.91%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Adherence to Antipsychotic Medications for Individual with Schizophrenia (saa)	66.43%	66.67%	0.24%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	50.30%	40.27%	-10.03%
Cholesterol Testing - 1-11 Years	39.24%	30.2%	-9.04%
Blood glucose and Cholesterol Testing - 1-11 Years	36.52%	28.16%	-8.36%
Blood glucose testing - 12-17 Years	63.00%	58.95%	-4.05%
Cholesterol Testing - 12-17 Years	44.27%	39.19%	-5.08%
Blood glucose and Cholesterol Testing - 12-17 Years	42.21%	37.41%	-4.80%
Blood glucose testing - Total	58.65%	52.94%	-5.71%
Cholesterol Testing - Total	42.55%	36.3%	-6.25%
Blood glucose and Cholesterol Testing - Total	40.26%	34.43%	-5.83%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.85%	0.7%	-0.15%
Appropriate Treatment for Children with URI (uri)			
3 months-17 Years	86.99%	87.64%	0.65%
18-64 Years	69.27%	70.99%	1.72%
65+ Years	NA*	NA*	NA
Total	85.14%	85.87%	0.73%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	52.31%	51.59%	-0.72%
18-64 Years	28.86%	28.74%	-0.12%
65+ Years	NA*	NA*	NA
Total	45.81%	45.42%	-0.39%
Use of Imaging Studies for Low Back Pain (lbp)	74.62%	73.16%	-1.46%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	NR	NR	NA
6-11 Years	NR	NR	NA
12-17 Years	NR	NR	NA
Total	NR	NR	NA
Use of Opioids and High Dosage (uod)	4.55%	4.31%	-0.24%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	20.58%	18.68%	-1.90%
Multiple Pharmacies	5.96%	5.59%	-0.37%
Multiple Prescribers and Multiple Pharmacies	3.09%	2.59%	-0.50%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	2.04%	2.05%	0.01%
18-64 years - >=31 Days covered	1.02%	0.94%	-0.08%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
65+ years - >=15 Days covered	NA*	NA*	NA
65+ years - >=31 Days covered	NA*	NA*	NA
Total - >=15 Days covered	2.04%	2.05%	0.01%
Total - >=31 Days covered	1.02%	0.94%	-0.08%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	79.52%	78.4%	-1.12%
45-64 Years	88.53%	87.33%	-1.20%
65+ Years	100.00%	80%	NA*
Total	81.59%	80.42%	-1.17%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	25.53%	42.48%	16.95%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	5.32%	8.85%	3.53%
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	42.11	73.68%	NA*
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years*	15.79%	42.11%	NA*
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	32.12%	39.09%	6.97%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	16.13%	12.33%	-3.80%
Total: Initiation of AOD Treatment: 13-17 Years	31.06%	38.84%	7.78%
Total: Engagement of AOD Treatment: 13-17 Years	15.26%	12.27%	-2.99%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	38.72%	36.97%	-1.75%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.92%	6.62%	-2.30%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	54.30%	61.93%	7.63%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	29.27%	37.93%	8.66%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	36.66%	37.64%	0.98%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.94%	6.8%	-3.14%
Total: Initiation of AOD Treatment: 18+ Years	40.16%	41.78%	1.62%
Total: Engagement of AOD Treatment: 18+ Years	13.12%	12.84%	-0.28%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	37.75%	37.48%	-0.27%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	8.66%	6.83%	-1.83%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	54.01%	62.25%	8.24%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	28.95%	38.04%	9.09%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Other drug abuse or dependence: Initiation of AOD Treatment: Total	35.56%	37.96%	2.40%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	11.44%	8.01%	-3.43%
Total: Initiation of AOD Treatment: Total	38.61%	41.32%	2.71%
Total: Engagement of AOD Treatment: Total	13.48%	12.75%	-0.73%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	88.19%	88.79%	0.60%
Postpartum Care	70.83%	75%	4.17%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	65.57%	60.39%	-5.18%
12-17 Years	64.94%	63.71%	-1.23%
Total	65.19%	62.52%	-2.67%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	NR	59.87%	NA
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	NR	77.07%	NA
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (3-11)	NR	52.86%	NA
Child and Adolescent Well-Care Visits (12-17)	NR	48.02%	NA
Child and Adolescent Well-Care Visits (18-21)	NR	23.56%	NA
Child and Adolescent Well-Care Visits (Total)	NR	47.94%	NA

NA= Data not available; NR= Not Reported; * indicates small denominator for rate calculation

Select Health uses Inovalon, a certified software organization, for calculation of HEDIS rates. Rates were audited by HealthcareDataCompany, LLC. CCME reviewed the rates for substantial (>10%) changes from last year to this year. As noted in *Table 16: HEDIS Measures with Substantial Changes in Rates*, Asthma Medication Ratio (amr) for 51–64 year-olds improved 12.15% from last year; Pharmacotherapy for Opioid Use Disorder improved by almost 22%. Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid improved 10.3%. Comprehensive Diabetes Care (cdc) declined 10.9% for HbA1c > 9%. The Eye Exam rate declined 12.11%. Follow-Up After High-Intensity Care for Substance Use Disorder (fui) for 13–17-year-olds declined 21.5% for 30-day follow up and 12.84% for the 7-day follow up. Metabolic Monitoring for Children and Adolescents of Antipsychotics Blood Glucose Testing measure for 1 to 11-year-olds declined 10%.

Table 16: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	64.04%	74.31%	10.27%
Asthma Medication Ratio (amr)			
51-64 Years	47.15%	59.3%	12.15%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	25.35%	47.21%	21.86%
Total	25.30%	47.21%	21.91%
Substantial Decrease in Rate (>10% decrease)			
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	46.03%	56.93%	-10.90%
Eye Exam (Retinal) Performed	55.42%	43.31%	-12.11%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	54.17%	32.65%	-21.52%
13-17 years - 7-Day Follow-Up	29.17%	16.33%	-12.84%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	50.30%	40.27%	-10.03%

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

Validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validating Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

For this review, two PIPs were submitted and validated. Topics for PIPs include Diabetes Outcomes and Well-Care Visits for the Foster Care Population. All the PIPs scored in the

"High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions are also included.

Table 17: Comprehensive Diabetes PIP

Comprehensive Diabetes Care Outcomes Measures	
The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8). The Comprehensive Diabetes Care control measure A1c slightly improved while the BP measure continued to trend negatively in 2020. Both measures were impacted by the COVID-19 pandemic and did not meet the plan's goal for the 75th percentile. A1c <8 measure showed a 3.56% increase from the previous year and met the plan's goal of a 2% increase. The slight improvement in the A1c <8 measure may be a result of increase in data exchange and increase use of the Category-ll codes. The plan has implemented a flat file data exchange with supplemental reports for providers and increased overall EMR remote access to effectuate a year-round medical record review program. The blood pressure control measure demonstrated an 8.04% decline and did not meet the goal. The member incentives continued and resulted in a less than 1% return rate and therefore did not indicate an improvement. The results of this PIP would indicate that the incentive intervention was not effective. However, with the other confounding factors affecting the rates cannot be made and interventions will be continued in 2021.	
Previous Validation Score	**Current Validation Score**
84/85=99% High Confidence in Reported Results	90/91= 99% High Confidence in Reported Results
Interventions	
• Fall/Winter 2020 Newsletter Article: "How the A1c test can help you manage diabetes". • HbA1c testing gift card incentive voucher mailed to 466 members. • Implemented a flat file data exchange with supplemental reports for providers. • Control measures added to value-based programs (i.e., PCP-QEP, FQHC-QEP, and large hospital systems). These programs were in development in 2018, expanded for 2019, and continue to expand in 2020. • Continued use of Category-ll codes and exploring more options for data exchange with direct EMR access. • The plan is currently working with lab vendors for monthly data file exchanges. • Virtual provider training and quality meetings were conducted throughout the year. • Spring-2020 Newsletter Article: "What is medicine adherence?"	

CCME provided the following recommendations for the Diabetes Outcome PIP as displayed in *Table 18: Performance Improvement Project Recommendations.*

Table 18: Performance Improvement Project Recommendations

Project	Section	Reason	Recommendation
Comprehensive Diabetes Care Outcomes	Was there any documented, quantitative improvement in processes or outcomes of care?	The HbA1c <8% improved from 35.71% to 36.98% The BP Control (<140/90) did not improve. The rate decreased from 57.68% to 53.04%.	Continue interventions to improve rates by addressing member and provider barriers. Determine if analysis should focus primarily on the blood pressure control rate through the data sharing and MRR review interventions.

Table 19: Well-Care Visits PIP

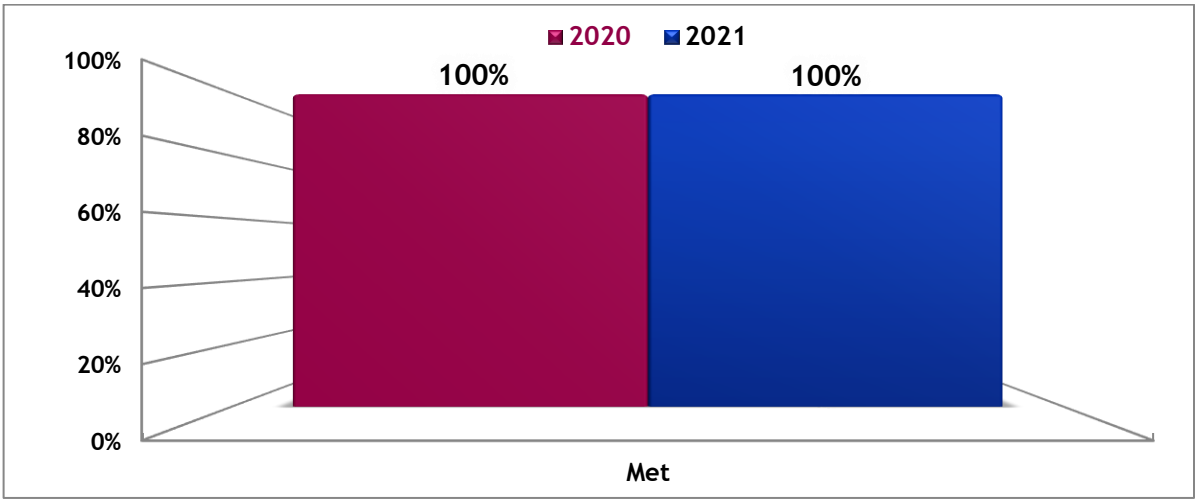
Well-Care Visits for Children and Adolescents in Foster Care in South Carolina	
The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase the compliance with well-care visits for the children and adolescents in the foster care. During the pilot project, Select Health found there was no defined process point for sharing health, behavioral health, dental history or detail prior to placement and no process for sharing information between Select Health and SC Department of Social Services (SCDSS) while the child is in placement. Another significant finding of the Health Care Pilot and Case Process Review was that, despite the fact that virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) well-child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits. Two of three (66%) well-child visit measures demonstrated improvement from the CY2019 baseline year: Adolescent Well-Care Visit (awc) and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34). One of three (33%) well-child visit measures, Well-Child Visits in the First 15 Months of Life (w15) 6+ Visits, experienced a small decrease from the CY2019 baseline year. All three measures (awc, w15, and w34) experienced substantial improvements from CY2018 to CY2020 — 5.94 percentage points, 3.37 percentage points, and 9.43 percentage points, respectively. The wcv is a new measure for this PIP. Baseline rates were presented for 3-11 years, 12-17 years, 18-21 years, and total.	
Previous Validation Score	**Current Validation Score**
83/83=100% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results
Interventions	

Well-Care Visits for Children and Adolescents in Foster Care in South Carolina
• Data mapping corrections: Select Health, SCDSS, and SCDHHS will convene numerous times each year to assess the need to refresh, modify, update and/or adjust the operational process-flows illustrated within the data maps. • Foster Care Program Implementation. • Rounds: Select Health Medical Directors will coordinate with SCDSS to perform clinical rounds on members. • Establishment of a SCDSS and Select Health Operations Team (facilitated by SCDSS): Workgroups and subcommittees have been created to increase collaboration among all parties and to help support the operational needs of the new program. • Data Sharing/Exchange, Analysis and Reporting: The SCDSS nightly data feed rosters of children in care is sent to SCDHHS to certify Medicaid eligibility and then on to Select Health who can then begin providing comprehensive assessments, well-child care, needed follow-up services and care management as needed. Additionally, Select Health has begun to produce gap-in-care reports to track utilization and care gaps, care management rosters, and other necessary information for SCDSS managers and field staff. A formal data-sharing agreement was fully executed in 2020 and will be assessed frequently for completeness, utility, and modifications based on relevant needs and technical parameters. Ad hoc report requests are submitted by SCDSS and fulfilled by SHSC under the *SCDHHS 2018 MCO Contract* provisions. • Member & Provider Data Portal Access for SCDSS Staff: Select Health will create a special user type for SCDSS Staff to access and use the NaviNet Provider Portal. Use of this resource will allow SCDSS Staff the ability to access member-level data for Foster Care members only.

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

Select Health continues to meet all the requirements in the Quality Improvement section of the review as noted in *Figure 6*.

Figure 6: Quality Improvement Findings



Strengths

- Select Health provides information to members and providers about the QI Program via the Select Health website. The website contained information regarding the 2020 achievements and strengths, satisfaction survey results, 2021 program goals, and how a member or provider can obtain more information.
- Additional network providers were recruited to serve on the Quality Assessment Performance Improvement Committee.
- The following HEDIS MY 2020 measure rates were strengths for Select Health since their rates had a greater than 10% improvement:
  - Asthma Medication Ratio (amr) for 51–64-year-olds improved 12.15% from last year.
  - Pharmacotherapy for Opioid Use Disorder improved by almost 22%.
  - Pharmacotherapy Management of COPD Exacerbation - Systemic Corticosteroid improved 10.3%.
- All performance improvement projects scored within the "High Confidence" range for the reported results.

Weaknesses

- There was no documented, quantitative improvement in processes or outcomes of care for the Comprehensive Diabetes Care Outcomes PIP.

Recommendations:

- Continue interventions to improve rates by addressing patient and provider barriers. Determine if analysis should focus primarily on the BP control rate through the data sharing and MRR review interventions.

E. Utilization Management

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

Review of Select Health's Utilization Management (UM) Program included various UM documents, the Select Health website, medical necessity determination processes, pharmacy requirements, the Care Management Program, and a review of approval, denial, appeal, and care management files.

The UM Program Description and UM policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in South Carolina. The Population Health Management (PHM) Strategy describes

processes to identify and assist members with support to address their social, medical, and behavioral health needs.

Select Health ensures network practitioners can provide feedback about UM activities, such as appeals, grievances, and UM guidelines and criteria during quarterly QCCC meetings. CCME noted that the QCCC Charter indicates four external practicing PCPs and specialists are members; however, the QCCC Committee List reflects three external providers. Recommendations were offered to address this.

Timeliness requirements for UM determinations are correctly documented. The turn-around-time goal of 100% for UM decision-making was not achieved. Onsite discussion revealed staffing issues, such as vacancies and Family Medical Leave, were reported as barriers and active recruitment efforts are underway to fill vacant positions. Reviews of service authorization requests are conducted using McKesson's InterQual, internal clinical review criteria, and other established criteria. For behavioral health service authorization requests, ASAM criteria is used. Select Health assesses consistency in criteria application and decision-making through annual inter-rater reliability testing for physician reviewers and clinical reviewers for medical and behavioral health services. All reviewers, including pharmacy staff, received passing scores.

Review of approval and denial files reflected consistent decision-making using approved criteria according to an established hierarchy. Physical health, behavioral health, and pharmaceutical utilization decisions are made by appropriate professionals within required timeframes. Approval notices containing all required information were faxed to providers and Adverse Benefit Decision notices were written in clear language for a layperson to understand with instructions for requesting an appeal.

PerformRx is the pharmacy benefit manager and is responsible for implementing pharmaceutical services. Select Health uses the most current version of the Preferred Drug List, which is accessible on the website, to fulfill pharmacy requirements.

The Population Health Management Strategy Document, and related policies, such as Policy PH-CC 201S, Care Management Standard of Practice, and Policy PH-CC 00S, Complex Care Management Assessment, describe Select Health's Case Management and Care Coordination Programs. The documents define and outline Select Health's approach to providing medical and behavioral health CM services and provide direction and guidance to staff. Additionally, Select Health has policies describing Transitional Care Management activities provided to identified members.

CM files reflect staff are providing case management services according to the member's risk level and needs. Health risk assessments are conducted by qualified licensed health professionals, such as nurses and social workers, who are appropriate for the member's health condition.

As noted in Table 20, during the 2020 EQR, Select Health had deficiencies in documenting the process used to provide coordinated health care for members that require Targeted Case Management Services. Select Health has revised the Population Health Policy Care Management Standard of Practice policy to address this deficiency.

Table 20: Previous Care Management QIP Items

Standard	EQR Comments
V. D Care Management and Coordination	
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	Select Health applies the Complex Care Management Standards of Practice to the care management program. CCME was not able to identify how the plan provides coordinated health care for members that require Targeted Case Management (TCM) Services, such as children in the juvenile justice system, members with sickle cell disease, and members who are sensory impaired. During the onsite teleconference, staff confirmed the requirements for TCM services were unexpectedly not documented in a policy. *Quality Improvement Plan: Include the requirements for TCM services in a policy or other documents, as noted in SCDHH Contract Section 4.2.27*
Select Health: The Population Health Policy Care Management Standard of Practice PH – CC 201S was revised to include the requirements for TCM services on December 10, 2020. Please see the bottom of page 5 and top of page 6 of the updated policy. A copy of the updated policy is included.	

Appeals

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

Select Health has established policies for handling appeals of adverse benefit determinations. The policies are consistent with requirements of the *SCDHHS Contract* and Federal Regulations. The appeal timeframe begins upon receiving a verbal or written request. Definitions of appeal terminology and information about who may file an appeal are correctly documented. Procedures for filing an appeal are clearly provided and consistently documented across policies, the Member Handbook, the Provider Manual, and the website.

Onsite discussion confirmed the Plan is aware of changes to the appeals process, according to *42 CFR § 438.402 (c) (3)*, which no longer require a member's verbal appeal to be followed by a signed, written appeal; however, page 13 of Policy MMS.100, Member Grievances and Appeals Process, has outdated language. The review of appeal files reflected timely acknowledgement, resolution, and notification of determinations. The

determinations were made by professionals with appropriate clinical experience. Resolution letters were written clearly and provided instructions for requesting a State Fair Hearing.

The UM Program is evaluated at least annually to assess its strengths and effectiveness. Overall, no major issues were identified with review of the UM Program.

As noted in *Figure 7: Utilization Management Findings*, Select Health received "Met" scores for 100% of the Utilization Management standards.

Figure 7: Utilization Management Findings

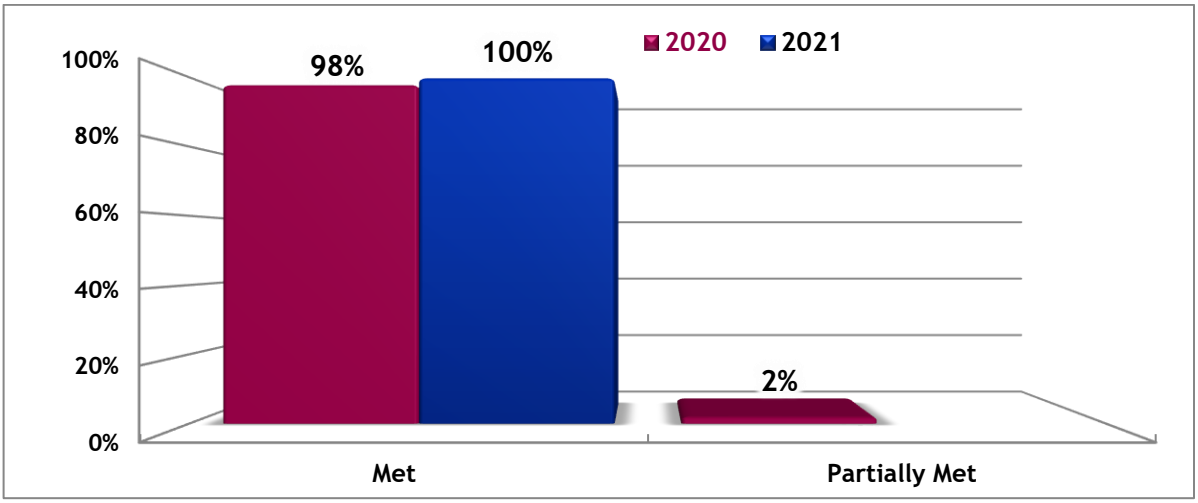


TABLE 21: Utilization Management Comparative Data

SECTION	STANDARD	2020 REVIEW	2021 REVIEW
Care Management and Coordination	The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.

Strengths

- Select Health is conducting a COVID-19 project that includes outreach and education to all plan members.
- The Population Health Management Strategy document and the UM Program Description are well-written and appropriately describe the goals, scope, and structure of the UM Program.
- Timeframe requirements for appeal resolutions are met.

- The Plan provides assistance with appeals and services upon request, including providing interpreter services and materials translated in other languages.

Weaknesses

- Page 13 of Policy MMS.100, Member Grievances and Appeals Process, includes outdated language indicating that a member's verbal appeal must be followed by a signed, written appeal.

Recommendations

- Ensure documents and materials are updated with current appeal filing procedures according to requirements in *42 CFR § 438.402 (c) (3)* and the *SCDHHS Contract, Section 9.1.13.2*.

F. Delegation

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

CCME's External Quality Review of Delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials.

For this review, Select Health reported 13 delegation agreements, as shown in *Table 22: Delegated Entities and Services*.

Table 22: Delegated Entities and Services

Delegated Entities	Delegated Services
BHM	Behavioral Health Utilization Management
CareNet	Member Call Center
NIA	Radiology Utilization Management and Provider Call Center Services
PerformRx	Pharmacy Benefit Management
AU Medical Center Prisma Health Health Network Solutions (HNS) Medical University of South Carolina (MUSC) PSG Delegated Services Regional Health Plus (RHP) Roper St. Francis (RSF) St. Francis Physician Services (SFPS) Lexington Health, Inc.	Credentialing and Recredentialing

Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, addresses processes for contracting with and conducting oversight of delegated vendors and entities. Processes include conducting pre-delegation evaluations of potential delegates' abilities to perform the delegated functions and annual oversight of each delegate. Ongoing monitoring is conducted through routine delegate reporting. The policy addresses actions that may be taken in response to poor performance, up to an including termination of the delegation agreement. Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, addresses processes for contracting with, and conducting oversight of, delegated credentialing entities.

Delegation agreements are implemented with all delegates and specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.

Documentation of preassessment activities, annual oversight, and ongoing monitoring were provided for each of Select Health's delegates. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan. No issues were identified in the current review of delegation.

During the previous (2020) EQR, it was noted that Select Health's Credentialing / Recredentialing file review tool did not include the verification of the Clinical Laboratory Improvement Amendment Certificate and the requirements for nurse practitioners, as stated in Exhibit B of Policy CP 210.107. The current EQR confirmed these issues were appropriately addressed and tools include all required elements. See *Table 23: Previous Delegation QIP Items* for more information about the previously identified issue and Select Health's response.

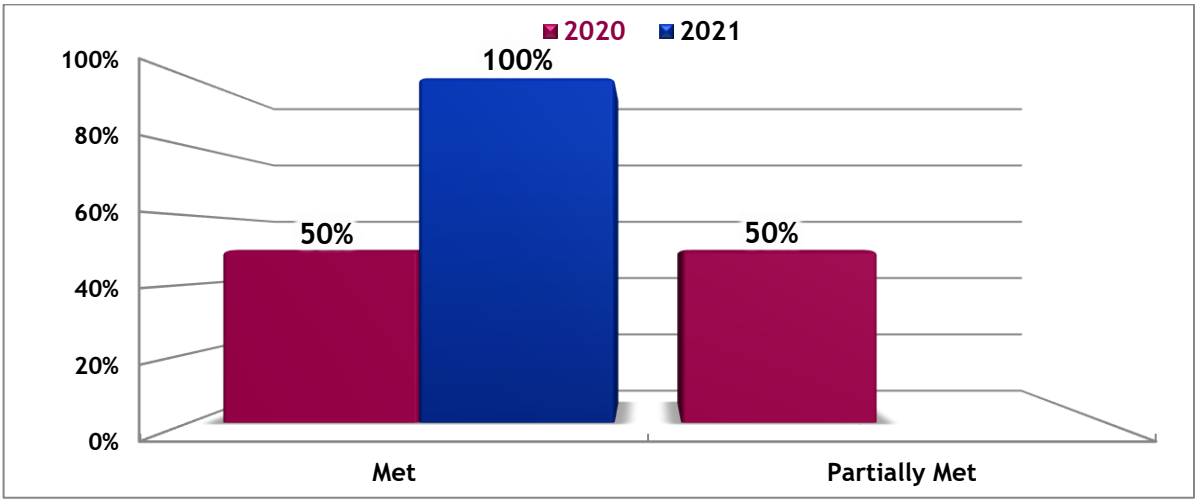
Table 23: Previous Delegation QIP Items

Standard	EQR Comments
VI. DELEGATION	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, includes the process for annual oversight monitoring of all delegates. A score of at least 95% is required to pass the annual assessment. Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, includes the process for the annual monitoring of the credentialing delegates. Select Health requires all credentialing delegates to score 100% in all areas that have been delegated. For delegates not meeting the goal, a corrective action plan is required.

Standard	EQR Comments
	The results of the annual monitoring of all delegates were provided. For delegates not meeting the monitoring goals, corrective action(s) were implemented. Select Health provided a copy of the Credentialing/Recredentialing file review tool and the monitoring results for the delegates conducting the credentialing and recredentialing activities. The tools did not include the verification of the Clinical Laboratory Improvement Amendment (CLIA) Certificate and the requirements for the nurse practitioners as required in Exhibit B of Policy CP 210.107. *Quality Improvement Plan: Ensure delegate oversight documentation for the file review of delegates conducting credentialing and recredentialing activities includes CLIA Certificates and the requirements for Nurse Practitioners.*
Select Health's Response: The SC State, Federal, Medicare File Review tool has been updated to include file review of CLIA and NP/PA protocols moving forward for 2021 audits. These updates can be found from columns CA-CK. A copy of the revised tool is included.	

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

Figure 8: Delegation Findings



Strengths

- Policies and procedures detail Select Health's processes and requirements for pre-delegation assessments, implementation of delegation agreements, annual oversight of delegated activities, and ongoing monitoring.

- Delegation agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.
- Documentation of preassessment activities, annual oversight, and ongoing monitoring for each of Select Health's delegates included deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.

G. State Mandated Services

42 CFR Part 441, Subpart B

Select Health's EPSDT Program follows the American Academy of Pediatrics periodicity schedule for required screenings and health treatments. The plan monitors compliance with immunization and EPSDT requirements by reviewing PCP rates for immunization and well-child visits and through random medical record reviews conducted by the Quality Improvement Department. Additionally, Select Health Blue provides all core benefits specified by the *SCDHHS Contract*.

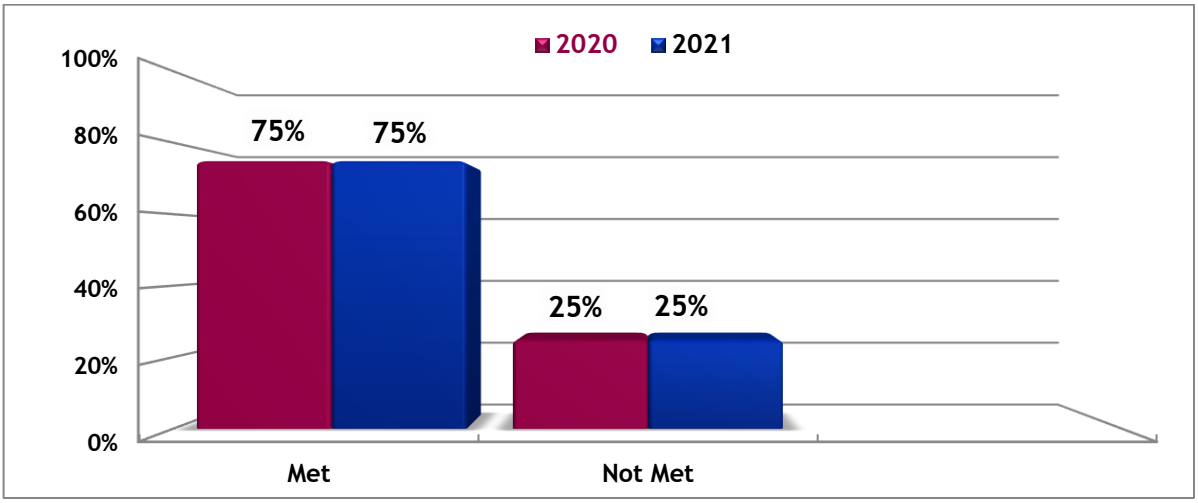
As noted in Table 24, deficiencies from the 2020 EQR were addressed by the health plan in their response to the Quality Improvement Plan; however, the issues were noted again during the current EQR.

Table 24: Previous QIP Items

Standard	EQR Comments
VII. STATE MANDATED	
3. The MCO addresses deficiencies identified in previous independent external quality reviews	A deficiency noted in the previous EQR related to documentation of network adequacy standards in annual reporting documents was noted again in the current EQR. *Quality Improvement Plan: Ensure all deficiencies identified during the EQR process are addressed with actions to correct the deficiency and prevent recurrence.*
Select Health: The health plan will incorporate all items identified in the EQR QIP report in its ongoing monitoring and auditing plans for the coming year. A focused review of these items will be performed as well during the course of the year with each department leader to ensure ongoing compliance and visibility. Additionally, the health plan is creating a written policy regarding its monitoring and auditing activities to ensure there is a formal documented process for addressing EQR identified deficiencies as part of its monitoring and auditing plans.	

As indicated in *Figure 9: State Mandated Services*, 75% of the standards in the State Mandated Services section were scored as "Met."

Figure 9: State Mandated Services



Strengths

- Select Health ensures that all contractually-required benefits are provided.
- Alerts in the provider portal, monthly emails, and provider education are examples of methods used to inform providers of members who are due for or have missed EPSDT visits.

Weaknesses

- Several deficiencies identified during the previous (2020) EQR were noted again during the current EQR.

Quality Improvement Plans

- Implement actions to address all deficiencies identified in the EQR process

ATTACHMENTS

Attachment 1: Initial Notice, Materials Requested for Desk Review

Attachment 2: Materials Requested for Onsite Review

Attachment 3: EQR Validation Worksheets

Attachment 4: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

September 13, 2021

Ms. Courtnay Thompson
Market President
Select Health of South Carolina
4390 Belle Oaks Drive, Suite 400
North Charleston, South Carolina 29405

Dear Ms. Thompson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2021 External Quality Review (EQR) of Select Health is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **November 17th and November 18th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **September 27, 2021.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow health plans under review to submit desk materials directly to CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2021

MATERIALS REQUESTED FOR DESK REVIEW

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

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. Please provide a list of all current employees, the employees title, and credentials.

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

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

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

Excel Spreadsheet Format

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

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

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

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

9. A description of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2020 and 2021.

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

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

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

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

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

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

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

18. A complete list of all members enrolled in the case management program from October 2020 through September 2021. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

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

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

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

23. A copy of the Grievance, Complaint and Appeal logs for the months of October 2020 through September 2021.

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

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

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

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

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

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

32. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

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

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.

35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report

b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
c. reporting frequency and format;
d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
f. denominator calculations methodology, including:
    1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the denominator;
g. numerator calculations methodology, including:
    1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
    2) specifications for all components used to identify the population for the numerator;
h. calculated and reported rates.
i. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCP's (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) for the months of October 2020 through September 2021. Include any medical information and physician review documentation used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) for the months of October 2020 through September 2021, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Copies of the most recent Geo Access mapping reports for all provider types.
3. SELECT HEALTH Quality Index HEDIS Measure Results for Reporting Year (RY) 2021/Measurement Year (MY) 2020 (Earnback Excel file).
4. Policy 391.100, Preventive and Clinical Practice Guidelines (or an alternate policy covering these topics).

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Select Health**
Name of PIP:	**WELL-CARE VISITS FOR FOSTER CARE MEMBERS**
Reporting Year:	**2020**
Review Performed:	**11/2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale were reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aims and study question were reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addressed key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP included all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS sampling technical specifications were used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS sampling technical specifications were used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS sampling technical specifications were used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	HEDIS measures were used.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators were related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were based on HEDIS measures.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Administrative records and medical records were sources of data.

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data pulled according to HEDIS calculation software.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments were reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	HEDIS staff used for data collection.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented for all indicators.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Initial and repeat measurements were listed where applicable.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	AWC improved; W15 did not improve; W34 improved; W30 (new measure) and WCV (new measure) had baseline rates only.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was related to interventions that focus on data access, and findings from pilot and case process review.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Improvement was related to interventions on data sharing and telehealth opportunities.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**91**
Project Possible Score	**91**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Select Health**
Name of PIP:	**DIABETES OUTCOME MEASURES**
Reporting Year:	**2020**
Review Performed:	**11/2021**

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on research and analysis of enrollee care needs as stated on page 1.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Study aim was found in the project documentation.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services were addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations were included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS Hybrid methodology was used.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid methodology was used.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS Hybrid methodology was used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures were Hba1c >9, Hba1c<8, and BP control <140/90.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measured changes in processes of care and health status.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specified data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design described the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data was used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was conducted according to hybrid methods
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The personnel that are involved in the data collection and their qualifications were mentioned.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	After the onsite, report was uploaded with corrected bar chart percentage rates.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and repeat measurements were documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation included both qualitative and quantitative discussion of results.

Component / Standard (Total Points)	Score	Comments
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**PARTIALLY MET**	The HbA1c <8% improved from 35.71% to 36.98%. The BP Control (<140/90) did not improve. The rate decreased from 57.68% to 53.04%. *Recommendation: Continue interventions to improve rates by addressing member and provider barriers. Determine if analysis should focus primarily on the blood pressure control rate through the data sharing and MRR review interventions.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement was a result of the data and provider-based interventions.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	No improvement to assess.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**90**
Project Possible Score	**91**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**Select Health**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2020**
Review Performed:	**2021**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2021

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall assessment			Plan uses NCQA certified software, Reveleer and Quality Spectrum Insight™ from Inovalon. Audit report noted compliance for HEDIS measures.

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

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

Plan's Measure Score	**75**
Measure Weight Score	**75**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	**2020**
Review Performed	**2021**

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity (updated based on October MY2020 version of EQR protocol 6).

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Adult MY2020

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were used. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,692. The number of total completed surveys was 279, for a 17% response rate. This response rate was lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020 ***Recommendation:*** *Continue working with vendor to increase response rates, as they are below the NCQA target response rate of 40% and may impact the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	**2020**
Review Performed	**2021**

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity (updated based on October MY2020 version of EQR protocol 6).

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020

Survey Element		Element Met / Not Met	Comments and Documentation
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	The response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Child MY2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Child MY2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were used. *Documentation:* SPH Analytics Member Satisfaction Report- Child MY2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child MY2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child MY2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 2,237. The number of total completed surveys was 317, for a 16.6% response rate. This response rate was lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* SPH Analytics Member Satisfaction Report- Child MY2020 ***Recommendation:*** *Continue working with vendor to increase response rates, as they are below the NCQA target response rate of 40% and may impact the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Adult MY2020

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	**2020**
Review Performed	**2021**

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity (updated based on October MY2020 version of EQR protocol 6).

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020

Survey Element		Element Met / Not Met	Comments and Documentation
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates were in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate was reported and bias in generalizability was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan was documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC MY2020

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were used. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures were in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1607 with 257 completed for a 17.2% response rate for the total sample. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020 ***Recommendation:*** *Continue working with vendor to increase response rates, as they are below the NCQA target response rate of 40% and may impact the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC MY2020

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Select Health
Collection Date:	2021

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy SHC 168.001, Policy and Procedure Program Management and Format Guidelines, indicates that all policies and procedures are reviewed annually by the appropriate department leaders with follow-up review and approval conducted by the Policy and Procedure Subcommittee. Onsite discussion indicated that the Policy and Procedure Team meets monthly to review and revise policies as needed. Policy updates are distributed to staff.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Courtnay Thompson is the Market President.
1.2 Chief Financial Officer (CFO);	X					Jan Fuller is Director of Finance.
1.3 * Contract Account Manager;	X					The Contract Account Manager is Erin Garian.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					
1.5.1 Pharmacy Director,	X					The Pharmacy Director is Kelly Martin.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Quality Improvement Director is Nate Patterson.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Provider Services Director is Peggy Vickery.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Kevin Vaughan is the Member Services Director.
1.8.1 Member Services Staff,	X					Select Health is currently recruiting for 15 vacant Customer Services positions. *Recommendation: Monitor the current back-up plan to ensure that Customer Service responsibilities are met and review the recruitment process for the 15 vacant positions.*
1.9 *Medical Director;	X					Kirt Caton, MD is the Market Chief Medical Officer.
1.10 *Compliance Officer;	X					Select Health's Compliance Officer is Kathryn Gailey.
1.10.1 Program Integrity Coordinator;	X					
1.10.2 Program Integrity FWA Investigative/Review Staff;	X					
1.11 * Interagency Liaison;	X					The Interagency Liaison is Kelsey Austin.
1.12 Legal Staff;	X					Robert Tootle is identified in Select Health's legal representative.
1.13 Board Certified Psychiatrist or Psychologist;	X					Michelle Cooke is Select Health's psychologist.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Select Health's claims payment and benchmark standards align with the State's requirements (90% in 30 days, 99% within 90 days). Additionally, Select Health's ISCA documentation included a detailed claim processing guide specific to the organization's claim adjudication system.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Select Health is able to accept and generate HIPAA compliant electronic transactions. The organization's current claims data statistics reflect 97% of claims are submitted electronically and 3% are submitted on paper.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health's ISCA documentation notes that the organization has automated processes to collect enrollment information daily. Enrollment data is processed within 24 hours of receipt. Enrollment data that is incomplete or inaccurate is recorded and summarized in an error report which is sent to the organization's enrollment department for review.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Select Health's ISCA documentation indicates the organization can collect the necessary data and produce reports that are required by the State. Specifically, the organization included a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						third party HEDIS compliance audit report which was completed in May 2021. Third party auditors found that Select Health satisfied all audit requirements and received a passing score.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Select Health provided policies and procedural documentation that demonstrates the organization is capable of addressing the State's data security requirements. The organization provided policy documents including, but not limited to, patch management, remote access, access control, encryption, and data retention. Those policies are up-to-date and adhere to industry best practices. Additionally, the organization requires staff and contractors to complete training to protect Protected Health Information and Personally Identifiable Information.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Select Health provided policies and procedural documentation that demonstrates the organization is capable of addressing the State's requirements. The organization's access management policy is structured around providing staff the least necessary privileges necessary to perform their duties. Additionally, altering or escalating staff access privileges is addressed thoroughly in the organization's access management policy.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Select Health's disaster recovery (DR) and business continuity (BC) plans are detailed and provide checklists for each team or department

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						that make up the organization's recovery measures. Additionally, the DR/BC plans address when to declare a disaster and the disaster notification process. Finally, Select Health has recently completed a successful recovery test of its infrastructure and services to a standby data center.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Select Health's Compliance Plan addresses processes for detecting, preventing, and controlling fraud, waste, and abuse (FWA) and ensuring compliance with State and Federal regulations.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						Compliance training is mandatory, conducted upon hire and annually thereafter. AmeriHealth Caritas and Select Health require members of the Board of Directors, all associates, contingent

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						workforce members, subcontractor-vendors ,and first-tier, downstream, and related entities to receive Compliance training and education.
2.6 Lines of communication;						Select Health ensures open line of communication between the Compliance Officer and company personnel. Written confidentiality and non-retaliation policies encourage communication and reporting of incidents of potential fraud. Multiple avenues are available for reporting actual or suspected fraud, waste, and abuse.
2.7 Enforcement and accessibility;						The 2021 Compliance Plan states Select Health has policies and protocols to ensure prompt responses to identified noncompliance/detected offenses, including internal and external warning letters, internal remediation and corrective action initiatives, investigation protocols for fraud, waste, and abuse, and reporting to regulatory agencies.
2.8 Internal monitoring and auditing;						An important component of both the corporate and local health plan Compliance Program is the use of audits and other evaluation techniques to monitor compliance and identify areas of non-compliance for correction.
2.9 Response to offenses and corrective action;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Committee meets quarterly and is comprised of, at a minimum, the Compliance Officer, and other executives. Quarterly Compliance Committee meeting minutes were provided for review.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Policy 106.600.003, Internal Prospective Data Mining, outlines the role of the Program Integrity Department in preventing, detecting, investigating, and reporting fraud, waste, and abuse.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy 106.400.001, Recovery Project Submission and Processing, outlines that if an overpayment is identified that needs to be recouped from a provider on suspension, the SIU will initiate the overpayment recovery via the Program Integrity Reporting and Recovery team.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
consistent with state and federal regulations regarding health information privacy.						

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The Credentialing Program 2021 (Credentialing Program Description) was last revised in September 2021 and includes the program's scope, criteria, goals, and structure, and information about confidentiality. Policy CR.100.SC, Health Care Professional Credentialing and Re-credentialing, and Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, describe processes and requirements for credentialing and recredentialing activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Credentialing Committee Charter defines the roles and responsibilities of the Credentialing Committee and describes the committee's membership. Only practicing practitioners are voting members and the chairperson, an AmeriHealth Caritas Medical Director, has the tie-breaking vote. The committee meets monthly, and the quorum is established as 51% of the voting membership. According to the Credentialing Committee Charter, members that attend less than 50% of meetings during the yearly evaluation period are counseled by the chairperson, and the chairperson can replace members whose attendance does not meet the benchmark. The Credentialing Committee meeting minutes for 11 meetings held from October 2020 through September 2021 reflected two voting members did not meet the attendance expectation. One attended only 36% of the meetings and one attended only 46% of the meetings. Onsite discussion revealed that alternate practitioners may have attended the meeting in place of the absent practitioners; however, this was not apparent in the attendance documentation in the minutes. Also, per the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						committee will represent a broad network of representation from all disciplines including mid-level practitioners. No mid-level practitioners are included in the membership of the committee. *Recommendation: Reinforce Credentialing Committee attendance expectations with committee members and take necessary steps to replace or remove members who do not meet the attendance expectation. If alternate practitioners attend meetings in place of voting members, clearly note this in the attendance documentation for the applicable meeting. Also, consider recruiting at least one mid-level practitioner for membership to comply with requirements in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.3 Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Processes for sanctioning providers in compliance with state and federal laws and regulations, contractual requirements, accreditation standards, and reporting requirements are detailed in Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Select Health routinely monitors its network to ensure adequate member access to primary care providers. The PCP access standards are documented in Policy NM 159.206, Availability of Practitioners, and are compliant with contractual requirements. Select Health's goal is to meet or exceed contractual geographic access standards by ensuring that 95% of members have access to PCPs within the required parameters.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Select Health of South Carolina Annual Assessment of Network Adequacy indicates that for the 2020 reporting year, Select Health met all requirements for time, distance, and member-to-provider ratios for all practitioner types, including PCPs.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Select Health routinely monitors its network to ensure adequate member access to specialty providers, ancillary providers, and hospitals. The access standards documented in Policy NM 159.206, Availability of Practitioners, and are compliant with contractual requirements. Select Health's goal is to meet or exceed contractual geographic access standards by ensuring that 95% of members have access to specialists within the required parameters. Policy 159.206 does not address access parameters for occupational therapy, physical therapy, and speech/audiology therapy. Although not referenced in the policy, a review of submitted Geo Access reports confirmed access to these provider types is measured. The Select Health of South Carolina Annual Assessment of Network Adequacy indicates that for the 2020 reporting year, Select Health met all requirements for time, distance, and member-to-provider ratios for specialists. *Recommendation: Revise Policy 159.206, Availability of Practitioners, to include the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						access requirements for occupational therapy, physical therapy, and speech/audiology therapy.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy NM 159.206, Availability of Practitioners, addresses Select Health's practices for monitoring network adequacy. Provider availability is reported to the Quality of Service Committee annually. An analysis report includes availability standards, performance goals, identification of variance from standards, barriers, opportunities for improvement, and a summary of recommendations to improve availability. For 2020, SHSC completed a comprehensive assessment for both physical health and behavioral health services. In addition to geographic access, the assessment took into consideration data regarding member experience with accessing the network, member cultural needs/preferences, and provider-to-member ratios.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Select Health's Cultural and Linguistically Appropriate Services (CLAS) Program was established in early 2005 and its goal is "to promote the delivery of services to people of all cultures, races, ethnic backgrounds, abilities and religions in a manner that recognizes values, affirms and respects the worth of the individual members and protects and preserves the dignity of each." Select Health measures and evaluates CLAS-related activities through internal audits,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member satisfaction surveys, other outcomes-based evaluations, and performance improvement methodologies. Reports of all CLAS activities are provided quarterly to the Quality of Service Committee. Select Health's website includes information about the plan's commitment to cultural competency, health literacy, cultural competency training, etc. As noted on the website and discussed during the onsite visits, in 2021, Select Health earned the Multicultural Health Care Distinction from the National Committee for Quality Assurance for a sixth time. This distinction "recognizes health plans for excellence in the delivery of culturally and linguistically appropriate services to plan members." Links on the website take the user to external resources from various sources including the Office of Minority Health. Some of the resources provide CME credits for physicians and physician assistants or contact hours for nurse practitioners.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements.	X					As noted in Policy NM 159.308, Assessment of Physician Directory Accuracy, corporate Provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Data Management staff maintain the Provider Directory across the AmeriHealth Caritas enterprise. Elements that must be included in the Provider Directory are detailed in this policy; however, it does not address all required elements. The missing elements include office hours, age groups, and website URLs. A review of the print version and the online Provider Directory confirmed all required elements were present. *Recommendation: Update Policy NM 159.308, Assessment of Physician Directory Accuracy, to include the following required Provider Directory elements: office hours, age groups, and website URLs.*
3.Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, lists the appointment access standards for PCPs, but does not include the requirements for wait times for scheduled routine appointments or for walk-in patients with non-urgent needs. Refer to the *SCDHHS Contract, Section 6.2.2.3*. The policy also includes appointment access standards for high impact and high volume providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, to include the requirements for wait times for scheduled routine appointments and for walk-in patients with non-urgent needs. Refer to the SCDHHS Contract, Section 6.2.2.3. As noted in the policy, Select Health assesses provider compliance with appointment access standards annually. The goal is that at least 90% of the provider offices meet or exceed the standards. All providers who are not compliant with access requirements are reviewed by the Provider Network Management Department. Survey results are reported to the QSC and QAPIC. The Select Health of South Carolina Accessibility of Services report for 2021, page three, indicates the access standard for regular/routine PCP appointments is 10 business days, where policy NM 159.203 lists the timeframe as 4-6 weeks, as stated in the *SCDHHS Contract, Section 6.2.2.3*. During the onsite, this finding was discussed, and Select Health later provided the following information via email: "In regards to the discrepancy found in the routine PCP appointment access parameter between Policy NM 159.203 and the Select Health of South Carolina Accessibility of Services report for 2021,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the report is correct and the survey was completed using a 10 business day timeframe which is within the 4 to 6 weeks contract requirement and it meets our policy requirements as well." This 10 business day timeframe is stricter than the routine PCP appointment standard documented in the Provider Manual, page 51, to which providers are informed that they must adhere. *Quality Improvement Plan: Ensure appointment access studies are conducted using the parameters that PCPs are instructed they must comply with.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			As part of the annual EQR process for Select Health Plan, a provider access study was conducted focusing on primary care providers. From a list current providers supplied by Select Health, a population of 2,780 unique PCPs was identified, and a sample of 190 providers was randomly selected for the Access Study. Attempts were made to contact the providers to ask a series of questions regarding the access members have to the contracted providers. Calls were successfully answered 56% of the time (94 of 167) when omitting calls answered by voicemail messaging services. The success rate is a significant reduction from last year's rate of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						77% and is a statistically significant decline (p <.001). For those not answered successfully (n=73 calls), 53 (73%) were due to the physician no longer being active at the location. *Quality Improvement Plan: Determine barriers to updating provider status as active. Continue to review records to ensure provider contact information is updated and initiate new interventions to update provider information.*
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					As noted in Policy NM 159.102, Provider Orientation and Ongoing Training, the Provider Network Management Department is responsible for conducting initial and ongoing provider training. Initial training is conducted within 30 calendar days of the provider being placed on active status. Orientation topics follow the Provider Manual.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
provided under fee-for-service payment by SCDHHS;						
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Provider trainings are conducted in each region of the State on an annual basis and as needed. Ongoing training may be provided via face to face site visits, letters/faxes, Provider Manual updates, newsletters, mailings, regional

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						trainings, the website, or virtually through webinars. The Provider Training and Education webpage on Select Health's website includes links for: provider training, cultural competency training, HEDIS® 101, and the Jiva Provider Portal Participant Guide. Current and previous updates are found on the Provider Alerts tab page on Select Health's website. Of note, providers may sign up to get Select News emails containing important news and information.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy 391.100, Preventive and Clinical Practice Guidelines, and the 2021 Quality Improvement Program Description describe processes for adoption and ongoing review of preventive health guidelines. The guidelines are selected based on the demographics and needs of the member population using criteria from nationally recognized professional organizations. Provider input about the guidelines is provided through the Clinical Policy Committee. The guidelines are reviewed at least every two years and more frequently if changes occur.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					According to documentation in the Quality Improvement Program Description 2021, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PHGs are distributed via the website and provider portal, with hard copies available upon request. The Provider Manual includes general information about guidelines and charts documenting the periodic health guidelines for children and adults, as well as obstetrical care guidelines. Charts listing adult and pediatric preventive health guidelines are also found on the website. Additional information about adopted guidelines is found within the Provider Resources section of the website.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.7 Behavioral health services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Select Health develops clinical practice guidelines using criteria from nationally-recognized professional organizations to facilitate consistent, evidence-based, cost-effective care and to promote consistency in provider practice and delivery of medical care. Input is provided from health plan practitioners. The adopted guidelines are relevant to member demographics, common health conditions, and concerns of the membership population. The guidelines are reviewed at least every two years and more often if changes occur.
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					Clinical practice guidelines are distributed via the website and provider portal, with hard copy available upon request. The Provider Manual, page 55, includes general information about clinical practice guidelines, and provides a link to providers to access the guidelines. However, the link takes the user to Select Health's Clinical Coverage Policies rather than to the clinical practice guidelines. The clinical practice guidelines were found at a different location on the website by conducting a search.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the Provider Manual to include the correct URL for the clinical practice guidelines.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Continuity and coordination of care are monitored annually between PCPs and other providers. Monitoring for continuity and coordination of care primarily occurs through the medical record review process. Additional considerations include member complaint, grievance, and appeal data, transfer data, annual member and provider surveys, Quality of Care concerns, etc. The Quality Management Department monitors and trends continuity and coordination of care. Feedback is given to appropriate quality committees and individual practitioners, and a summary report is presented to the Quality Assessment and Performance Improvement Committee annually as part of QI Program Evaluation. Appropriate action is initiated by the QAPIC when continuity and coordination of care issues are identified. CCME noted this summary report was provided to the QAPIC on 4/22/21.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, list required medical record documentation elements.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.		X				Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, do not include all required elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*. The Provider Manual, pages 19-21, includes a comprehensive list of medical record documentation elements and informs providers that Select Health PCP sites are monitored annually for compliance with the standards listed. *Quality Improvement Plan: Revise Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, to include all medical record documentation elements required by the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O).*
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Select Health monitors provider compliance to medical record maintenance and documentation standards through an annual medical record review (MRR) process, as documented in Policy QI

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						154.009, Medical Record Review. The annual MRR is conducted in conjunction with the Healthcare Effectiveness Data and Information Set (HEDIS) survey. The MRR is completed using the Medical Record Review Evaluation Form attached to Policy QI 154.009, and results are determined for each practitioner included in the MRR. Overall MRR performance is also measured. PCP offices included in the MRR who score below the expected benchmark are notified of identified deficiencies, and a follow-up review will be conducted. However, the policy does not include the benchmark score. Onsite discussion confirmed the benchmark is established as 90%. A corrective action plan is implemented for practices who continue to fall below the benchmark. The Quality Management Department prepares and reports an annual summary of performance to the Quality of Clinical Care Committee for review and recommendations. Documentation in the 2021 Annual Assessment of State Audits for Medical Record Documentation report indicates the MRR was completed in June 2021. The overall compliance rate was 99.75% (a 0.25 percentage point increase from the 2020 rate). Opportunities and interventions were documented. The report included the elements assessed; however, not all required elements from the *SCDHHS Policy and Procedure Guide for*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Managed Care Organizations, Section 15.7 (O) were included. *Recommendation: Ensure the annual medical record review includes an assessment of provider compliance with all medical record documentation elements specified in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O) and noted in the Provider Manual. Revise Policy QI 154.009, Medical Record Review, to include the benchmark score for medical record reviews.*
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy MEM 129.107, New Member Orientation Calls, indicates that New Member packets and ID Cards are mailed within 14 days of enrollment and an orientation call is conducted to confirm the member received the packet.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						The Copayment Reference Guide is included in the New Member Packet and located on the member website. Information is listed in the Member Handbook.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Members may contact Member Services to schedule appointments or to select or change a PCP.
1.11 Procedures for disenrolling from the MCO;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						The Provider Directory description is found in the Member Handbook along with instructions to access the Provider Directory on the website. Members are instructed to contact Member Services to obtain information about a provider or to request a Provider Directory by mail.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						Sample pictures of the Healthy Connections and First Choice ID Cards are available in the Member Handbook. Members are informed of the importance of presenting both cards at the time of service.
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						Fraud and abuse are defined in the Member Handbook and on the website. Instructions are provided for reporting fraud, waste, and abuse to Select Health, SCDHHS, and South Carolina's Division of Program Integrity.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Member materials include tag lines in large print, explaining the availability of written translation or oral interpretation services, if needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy MEM 129.102, Disenrollment - Voluntary and Involuntary, defines processes for member-initiated disenrollment requests and involuntary disenrollment initiated by Select Health or SCDHHS. Select Health must request member disenrollment in writing to SCDHHS. This is reflected in the Member Handbook and website.
III D. Preventive Health and Chronic Disease Management Education						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					The Member Handbook provides information about preventive health services, case management programs, and instructions for obtaining educational support for medical, behavioral health, and pharmaceutical services. Select Health's website and mobile app have tools and information available on a variety of health topics. Additionally, the plan sends targeted mailers, such as an EPSDT brochure or member newsletter, and makes calls to eligible members reminding them of screenings and well visits.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Select Health contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct the Adult and Child surveys.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						All response rates decreased from the 2019 response rates and were below the NCQA target of 40%. *Recommendation: Continue working with vendor to increase response rates, as they are below the NCQA target response rate of 40% and may affect the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.*
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					The Survey workgroup document showed the Child survey met goals for all but three measures: Getting Needed Care, Getting Care Quickly, and Coordination of Care. The other six measures did meet the 75th percentile goal, with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Rating of Specialist showing the best percentile rank. The Adult survey had some strong improvements in the Rating of the Health Plan and Getting Care Quickly. Seven measures were below the goal. The Child with Chronic Conditions survey showed a strong increase in Rating of Specialist, improvement in seven other measures, and goals not met for seven measures.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					Response rates for member satisfaction surveys decreased from the 2019 response rates and were below the NCQA target of 40%. *Recommendation: Continue working with vendor to increase response rates, as they are below the NCQA target response rate of 40% and may affect the generalizability of the results. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy MMS.100, Member Grievances and Appeals Process, describes Select Health's processes for receiving, processing, and responding to member requests for complaints and grievances. Additionally, grievance information is provided via the Member Handbook, Provider Manual, and website.
1.1 The definition of a grievance and who may file a grievance;	X					
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;	X					Timeframes for grievance acknowledgement, resolution, and extension of resolution timeframes are correctly outlined in policy, the Member Handbook, and on the website.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MMS.100, Member Grievances and Appeals Process, states a summary of all member grievance is reported to the Quality of Service Committee annually.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The Quality Improvement Program Description 2021 was submitted for review. This program description is updated annually and submitted to the QAPIC and the Board of Directors for approval. The program description describes the quality improvement scope, goals, objectives, structure, and functions for the plan. Select Health provides information to members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and providers about the QI Program via the Select Health website. The website contained information regarding the 2020 achievements and strengths, satisfaction survey results, 2021 program goals, and how a member or provider can obtain more information. The AmeriHealth Caritas Board of Directors provides strategic direction for the QI program and retains ultimate responsibility for ensuring the program is incorporated into health plan operations. The development, implementation, monitoring, and evaluation of the QI program is delegated to the QAPIC.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Select Health performs baseline utilization measurements to calculate inpatient admission rates, length of stay, emergency room utilization rates, and clinical guideline adherence for preventive health and chronic illness management services to identify those areas that fall outside the expected rate and to assess for over- or under-utilization. One of the goals outlined in the QI Program Description is to reduce health care disparities. Annually, Select Health assesses the characteristics and needs of the member population, which includes children and adolescent members, members with disabilities, members with special needs, and members with serious and persistent mental illness. To further

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identify and reduce health care disparities, Select Health annually collects data on age, race, ethnicity, gender, primary language, and disability status to identify and facilitate delivery of culturally competent health care and identify opportunities to reduce the disparities.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Select Health develops a work plan annually that includes the deliverables, purpose or scope, frequency, and responsible party. The work plan is divided across three tabs (QAPI, QCCC, and QSC) and focuses on five goals: access, clinical quality, satisfaction, qualified providers, and compliance. The annual work plan is initiated by the Quality Management Department and forwarded to the QAPIC for review and recommendations.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QAPIC oversees Select Health's efforts to measure, manage, and improve the quality of care and services delivered to members, as well as evaluate the effectiveness of the QI Program. Primary responsibilities are included in the committee charter.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QAPIC is chaired by the Market President. Voting members include 7 practicing providers, one non-physician network provider, the Chief Medical Officer, several health plan medical directors, department directors, and managers. A quorum is established upon attendance of at least 50% of voting participants.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Last year, CCME recommended recruiting additional network providers to serve on this committee due to poor attendance. The committee membership list and minutes showed several new providers were added.
3. The QI Committee meets at regular quarterly intervals.	X					The QAPIC meets bi-monthly or at a minimum of five times a year.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting as evidenced by the committee minutes provided by Select Health. The minutes contained the meeting attendees, activities, decisions or recommendations, follow-up items, and responsible party.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					Select Health uses Inovalon, a certified software organization for calculation of HEDIS rates. Rates were audited by HealthcareDataCompany, LLC. The validation requirements were met.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					For this review, two PIPs were submitted and validated. Topics for PIPs include Diabetes Outcomes and Well-Care Visits for the Foster Care Population.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					All the PIPs scored in the "High Confidence in Reported Results" range/ There was no documented, quantitative improvement in processes or outcomes of care for the Comprehensive Diabetes Care Outcomes PIP.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Continue interventions to improve rates by addressing patient and provider barriers. Determine if analysis should focus primarily on the blood pressure control rate through the data sharing and MRR review interventions.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Providers from Select Health's network are invited to participate as voting members on the QAPIC, the QCCC, and the Credentialing Committee. Providers are informed in the Provider Manual of their expected cooperation with and participation in the QI program. The provider manual also encourages provider participation and includes contact information for participation.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Primary care physicians receive report cards that provide direct feedback on the practitioner's performance on key quality measures compared to a peer group within Select Health's network. Member level data on key quality metrics and care gap reports are also available for network PCPs. The care gap reports display a member-specific worksheet that identifies the care gap, along with a list of up-to-date services, for the provider's reference.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Select Health evaluates the overall effectiveness of the QI Program and reports this assessment to the Quality Assessment Performance Improvement Committee. The 2020 Quality Improvement Program Evaluation was provided. The program evaluation included the results of all completed activities conducted in 2020. Results of the evaluation are used to develop recommendations for improvement and to propose goals and objectives for QI activities for the upcoming year. There were no issues identified with the program evaluation.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The Utilization Management Program Description outlines the objectives, scope, and staff roles for physical health, behavioral health, and pharmaceutical services for Select Health's members. Several policies, including Policy UM.010S, Timeliness of UM Decisions, and Policy UM.008S, Clinical Criteria, provide guidance on utilization management (UM) processes and requirements.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					The UM Program Description and Policy UM.008S, Clinical Criteria, describe external and internal guidelines and criteria used to make clinical coverage decisions.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeframes for UM decisions are correctly documented in the UM Program Description and in Policy UM.010S, Timeliness of UM Decisions. The turn-around-time goal of 100% for UM decision-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						making was not achieved. Staffing issues such as vacancies and Family Medical Leave were reported as barriers. Onsite discussion revealed active recruitment efforts are underway to fill vacant positions.
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description clearly describes the roles and responsibilities of the UM Medical Director and the Behavioral Health Medical Director. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting reviews, chairing committees, and ensuring culturally competent care.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Select Health uses objective, evidence-based criteria and review guidelines such as InterQual, SC Medicaid Provider Manuals, and American Society of Addiction Medicine (ASAM) criteria to render medical necessity determinations for service authorizations, as indicated in Policy UM.008S, Clinical Criteria, and in the UM Program Description.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Policy UM.312S, Hysterectomy and Family Planning. Clinical staff review prior authorization requests to determine medical necessity and to ensure required forms and consents are obtained.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Approval files reflected that UM nurses review pertinent medical records, consider the local delivery system, and consider the member's individual circumstances while making UM decisions. UM clinicians consult with Medical Directors on service requests that do not meet criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					The Pharmacy Program Description explains that PerformRx is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Select Health including prior authorizations and pharmacy network management activities.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The UM Program Description explains that Select Health does not require prior authorization for emergency services. Policy UM.905S, Emergency Room Services, correctly describes emergency and post-stabilization service requirements and the member's ability to access them.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The UM Program Description and related policies describe Select Health's approach for ensuring UM decisions are conducted by qualified staff. Initial clinical reviews are conducted by licensed staff and Level II clinical reviews are performed by a licensed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						physician, pharmacist, or other appropriate healthcare practitioner. Non-licensed staff perform intake and initial screenings that do not require clinical interpretation and use scripted interview materials to obtain further information.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of approval files reflected utilization decisions are made within required timeframes.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Policy UM.003S, Standard and Urgent Prior Authorization, indicates that if sufficient information is not available to make a determination, the reviewer will request the information from the requesting provider. UM denial files showed that clinical reviewers requested additional information from providers, when necessary.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial files indicated Select Health ensures denial decisions are reviewed and determined by an appropriate physician.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files confirmed denial decisions are made according to the processes described in Policy UM.010S, Timeliness of UM Decisions, and Policy UM.017S, Notice of Adverse Determinations. Determinations were communicated verbally to the requesting provider. An adverse benefit

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determination letter, mailed to the provider and member, explains the basis for the denial and includes appeal procedures.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					The UM Program Description and policies, such as Policy MMS.100, Member Grievances and Appeals Process, describes Select Health's approach for handling and processing member appeals. Additionally, information is provided in the Provider Manual, Member Handbook, and on the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					Procedures for filing an appeal are described and outlined in Policy MMS.100, Member Grievances and Appeals Process, and in the UM Program Description. Select Health ensures members and member representatives have access to appeal information, processes, and procedures on the website. The Plan provides assistance with appeals upon request. Onsite discussion confirmed Select Health is aware of changes to the appeals process, according to *42 CFR § 438.402 (c) (3)*, which no longer requires a member's verbal appeal to be followed by a signed,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						written appeal. CCME identified the plan has begun updating appeal documents to reflect this change; however, page 13 of Policy MMS.100, Member Grievances and Appeals Process, has outdated language. *Recommendation: Ensure documents and materials are updated with current appeal filing procedures according to requirements in 42 CFR § 438.402 (c) (3) and the SCDHHS Contract, Section 9.1.13.2.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy MMS.100, Member Grievances and Appeals Process, and the UM Program Description correctly document the resolution timeframes for standard and expedited appeals and include information about extensions of the resolution timeframes.
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.	X					Requirements for continuation of benefits are addressed in Policy MMS.100, Member Grievances and Appeals Process.
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal files reflected staff follow appropriate appeal processes. Determinations were issued by appropriate reviewers and acknowledgments and resolutions were completed timely. The appeal start time began when Select Health received the original verbal or written request. Documentation of the criteria or professional clinical reasoning used to make determinations was included.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Select Health tracks, trends, and analyzes appeals for medical and behavioral health services. Results and analysis are documented in the UM Program Evaluation and reported to QAPIC.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					The Population Health Management Strategy Document and related policies describe Select Health's approach to Case Management and Care Coordination Programs. Descriptions for Complex Care Management, Transitions of Care, and initial screenings are included.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from care management.	X					Policy PH-CC 202 S, Referral To Care Management, and the Population Health Management Strategy Document describe methods for identifying and referring members into Case Management. Sources such as referrals, claims, medical records, and utilization management data can identify members who may benefit from case management.
3. The MCO provides care management activities based on the member's risk stratification.	X					Select Health uses the Johns Hopkins ACG® stratification system in addition to 3M Treo predictive modeling to stratify identified members into low, moderate, or high-risk categories. Select Health's approach to member engagement, based on the member's risk level, is outlined in the Population Health Management Strategy Document. It describes in detail the CM services provided to members in each targeted population subset: Keeping Members Healthy (Low Risk), Managing Emerging Risk (Moderate Risk), Managing Multiple Chronic Illnesses and/or Disabilities (High Risk Members), and Patient Safety/Outcomes across Settings (all members).
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Select Health uses CM techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process. Review of CM files reflected CM activities are conducted appropriately. Policy PH-CC 201S, Care Management Standard of Practice, describes processes to provide coordinated

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						health care for members that require Targeted Case Management Services. During the onsite, Select Health staff discussed the COVID 19 Care Management Outreach program. Members considered low/emerging risk for potential social determinant of health needs are proactively screened telephonically.
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy PH-CC 301 S, MCO Transition Coordinator, and Policy UM.706S, Continuity of Care, describe Select Health's approach for ensuring transitional care management is accessible to eligible members and outlines processes and requirements for managing transitions of care across healthcare settings. Additionally, Policy MED (PA) 150.400 describes how Select Health provides new members with continuation of their current medications up to 90 days without prior authorization, until the provider completes the prior authorization process.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Select Health confirmed Natasha McClendon is the Transition Coordinator. The Transition Coordinator ensures a safe and orderly transition for members coming into the plan and for members leaving Select Health. Activities include, but are not limited to,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						completing the Transition Plan, communicating with key internal and external members of the care team, and facilitating requests for health records.
6. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					Select Health performs an evaluation of the CM Program annually. The 2020 Population Health Strategy Impact Analysis provides a summary of CM program activities, reports measurement outcomes, determines the overall effectiveness of the CM Program, and offers recommendations for improvement for 2021. SPH Analytics was selected to conduct the 2020 Care Management Satisfaction Survey.
7. Care management and coordination activities are conducted as required.	X					Select Health use CM techniques to ensure comprehensive, coordinated care for all members in various risk levels according to a standard outreach process. Review of CM files reflected CM activities such as documentation of referral services, health education and support, and appropriate referrals and scheduling assistance.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over and under utilization.	X					Select Health analyzes and monitors utilization data. The assessment of the short stay initiative was summarized in the March 2021 KPI Dashboard report. The 2020 UM Program Evaluation presented data on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						several utilization measures such as trends for total inpatient admission inpatient utilization diagnosis codes, behavioral health inpatient monitoring, and outpatient utilization. Barriers, opportunities, and planned actions were included in the report.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					For this review, Select Health reported 13 current delegation agreements: •BHM – Behavioral Health Utilization Management •CareNet – Member Call Center •NIA – Radiology Utilization Management and Provider Call Center Services •PerformRx – Pharmacy Benefit Management

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Credentialing and Recredentialing agreements are in place with: •AU Medical Center •Prisma Health •Health Network Solutions (HNS) •Medical University of South Carolina (MUSC) •PSG Delegated Services •Regional Health Plus (RHP) •Roper St. Francis (RSF) •St. Francis Physician Services (SFPS) •Lexington Health, Inc. The delegation agreements specify activities being delegated, reporting responsibilities, performance expectations, and consequences that may result from noncompliance with the performance expectations.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, addresses processes for contracting with, and conducting oversight of, delegated vendors and entities. Processes include conducting pre-delegation evaluations of potential delegates' abilities to perform the delegated functions and annual oversight of each delegate. Ongoing monitoring is conducted through routine delegate reporting. The policy addresses actions that may be taken in response to poor performance, up to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and including termination of the delegation agreement. Delegation agreements are implemented with all delegates. Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, addresses processes for contracting with, and conducting oversight of, delegated credentialing entities. Documentation of preassessment activities, annual oversight, and ongoing monitoring were provided for each of Select Health's delegates. Reports of the monitoring and oversight included documentation of any deficiencies identified, the delegates' responses to any corrective action, and follow-up by the health plan.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Policy QI 154.012, Over and Under Utilization Monitoring & Reporting, indicates the Quality Department monitors for HEDIS-based measures such as Well-Child visits and immunizations.
1.2 performing EPSDTs/Well Care.	X					Select Health tracks provider compliance with performing EPSDT/Well-Child visits during HEDIS activities. The Provider Manual is one of several methods used to inform providers of EPSDT requirements. Alerts in the provider portal, monthly emails from Select Health, and provider education are examples of methods used to inform providers of members who are due for, or have missed, EPSDT visits.
2. Core benefits provided by the MCO include all those specified by the contract.	X					Select Health ensures all contractually-required benefits are provided. During the onsite, staff reported the Utilization Management department processes requests for BabyNet according to requirements outlined in the *SCDHHS Contract, Appendix E*. Information and instructions for BabyNet are noted in the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Issues identified during the previous EQR related to discrepancies in the timeframe for PCP appointment access and lack of improvement in the Telephonic Provider Access Study conducted by CCME were identified again during the current EQR. Quality Improvement Plan: Implement actions to address all deficiencies identified in the EQR process.