CCME

2020 External Quality Review

SELECT HEALTH OF SOUTH CAROLINA

Submitted: December 10, 2020

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2020 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 2019 Annual Review.

The goals of the review are to:

- Determine if Select Health is following service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2019 Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

The EQR process is based on Centers for Medicare & Medicaid Services (CMS)-developed protocols for EQRs of Medicaid MCOs. The review includes a desk review of documents; results from a two-day virtual onsite visit; a compliance review; validation of performance improvement projects and performance measures; a Telephonic Provider Access Study; 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 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 access Select Health's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas. Details of the review, as well as specific strengths, weaknesses, applicable corrective action items, and recommendations are found in the respective sections and narrative of this report.

Administration:

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

First Choice by Select Health is a subsidiary of AmeriHealth Caritas. Overall operations are led by the Market President, and the day-to-day direction, management, and coordination of business planning and administrative functions are the responsibility of the Director, Plan Operations and Administration. The Market Chief Medical Officer provides clinical leadership and oversees health care affordability and clinical quality initiatives. Select Health now has a dedicated Medical Director for Foster Care. This position and additional corporate and health plan Medical Directors provide support to the Market Chief Medical Officer.

Select Health's Information Systems Capabilities Assessment (ISCA) documentation indicates the organization is committed to data security and confidentiality. A disaster recovery plan is in place and was successfully tested recently. Select Health performs actual remote location disaster recovery testing, while many organizations perform abbreviated tabletop recovery exercises.

Select Health has compliance policies, procedures, trainings, and the Code of Conduct, Ethics, and Disciplinary Action in place and reviews these annually and as needed on an organization-wide basis. The Select Health 2020 Compliance Plan and Program Integrity Plan defines, monitors, and identifies corrective action processes for standards to guard against fraud, waste, and abuse.

Select Health implements guidelines by the Office of the Inspector General regarding effective lines of communication with oversight provided by the Compliance Officer and the Compliance and Privacy Committee. Internal monitoring of reported or suspected FWA is completed via collaborative effort to include the Special Investigation Unit and the Data Mining Team. The Compliance Department conducts timely, reasonable inquiries

into any conduct where evidence suggests there has been misconduct related to payment or service delivery. Select Health has established policies specific to confidentiality, which stipulate that all Company associates, during the course of business operations, have a responsibility for proper use and disclosure of member Protected Health Information. This information is regulated pursuant to the Health Insurance Portability and Accountability Act (HIPAA).

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

Select Health thoroughly documents processes and requirements for initial credentialing and recredentialing of providers in the Select Health of South Carolina Credentialing Program 2020 and associated policies. Credentialing and recredentialing activities are overseen by the Credentialing Committee, a subcommittee of the Quality Assessment Performance Improvement Committee. The committee is chaired by the Market Chief Medical Officer, and membership includes external providers with a variety of specialties.

Credentialing and recredentialing files were well organized and most required information was included. However, CCME identified issues in the files related to queries of the Social Security Administration's Death Master File (initial credentialing files) and primary source verification of the providers' Clinical Laboratory Improvement Amendment (CLIA) Certificates (recredentialing files).

The Select Health of South Carolina Availability of Practitioners Report documents standards for urban/suburban internal medicine providers and specialty types that are inconsistent with the standards defined in Policy NM 159.206, Availability of Practitioners. Select Health staff responded that these discrepancies were a result of typographical errors in the Availability of Practitioners Report. An additional report, the Select Health of South Carolina Accessibility of Services Report, indicates specialty providers were measured using an appointment access timeframe of six to eight weeks for routine care. This timeframe is inconsistent with Policy NM 159.203, Accessibility of Services/PCP After Hours Survey and High Volume High Impact Survey. This is a repeat finding from the previous year's EQR.

Select Health staff has adapted provider education processes in response to restrictions from COVID-19. Processes include more frequent telephonic contact, virtual training sessions, increased written communication (such as provider alerts and newsletters), and a dedicated section of the website for COVID-19 updates.

As part of the annual EQR process for Select Health, a provider access study was performed focusing on primary care providers. Calls were successfully answered 77% of the time when omitting calls answered by personal or general voicemail messaging services. The success rate dropped slightly from last year's rate of 81%.

Member Services:

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

Select Health has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New members receive a New Member Packet with instructions for contacting Member Services, selecting a primary care provider (PCP), and initiating services. All members have access to information and resources in the Member Handbook, in the Provider Manual, on the website, and in member newsletters. Select Health provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

A third-party vendor, SPH Analytics, continues to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The 2020 survey response rates fell below the National Committee for Quality Assurance (NCQA) target response rate of 40%.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

For the Quality Improvement (QI) section, CCME reviewed the Quality Improvement Program Description 2020, committee structure and minutes, performance measures, performance improvement projects, and the Quality Improvement Program Evaluation 2020. Select Health's Quality Improvement Program Description 2020 describes the program's structure, accountabilities, scope, goals, and available resources. Select Health reviews and updates the QI Program Description at least annually.

Select Health's QI Work Plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 Work Plans included the planned activity/deliverable, purpose/scope, target dates for completion, responsible party, and department.

The Quality Assessment Performance Improvement Committee (QAPIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The Quality Clinical Care Committee is a subcommittee of the QAPIC. This committee is responsible for monitoring the clinical care services and outcomes.

The QAPIC charter clearly outlines the committee's responsibilities. The QAPIC is chaired by the Market President and members include senior leaders, department directors, and other health plan staff. The committee charter states that three to six network providers are included as voting members of this committee. However, the committee membership lists only two providers. Staff indicated there were issues getting network providers to participate in the committee meetings. Recruiting for new network providers is ongoing.

Annually, Select Health evaluates the overall effectiveness of the QI Program and reports this evaluation to the QAPIC for review and recommendations. The Quality Improvement Program Evaluation 2019 addressed all aspects of the QI Program.

Performance Measures Validation

Select Health uses a NCQA-certified software organization for calculation of Healthcare Effectiveness Data and Information Set (HEDIS) rates, and the validation found all requirements were met. For several hybrid measures, Select Health chose to report the measure year 2018 rate instead of the rate for measure year 2019, a substitution that is allowed by NCQA. Of the rates reported, the comparison from the previous year to the current year revealed a strong increase in the rate for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) – Total. There were three measures that showed a decline of greater than 10%. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial changes in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2018	Measure Year 2019	Percentage Point Difference
Substantial Increase in Rate (>10% Improvement)			
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	26.03%	45.81%	19.78%
Substantial Decrease in Rate (>10% Decrease)			
Asthma Medication Ratio (amr)			
51-64 Years	59.77%	47.15%	-12.62%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	38.10%	25.53%	-12.57%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	26.67%	5.32%	-21.35%

Quality Withhold Measures

Select Health reported 16 quality clinical withhold measures for 2019. The 2019 rate, percentile, point value, and index score are shown in *Table 2: Quality Withhold Measures*. The Pediatric Preventive Care rates generated the highest index score followed by Diabetes, Women's Health, and Behavioral Health.

Table 2: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.35	90	6	4.45
HbA1c Control (< =9)	46.03	25	3	
Eye Exam (Retinal) Performed	55.42	50	4	
Medical Attention for Nephropathy	91.16	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	88.19	75	5	4.35
Breast Cancer Screen	60.49	50	4	
Cervical Cancer Screen	68.71	75	5	
Chlamydia Screen in Women (Total)	59.98	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	78.96	90	6	5.30
Well Child Visits in 3rd,4th,5th&6th Years of Life	76.72	75	5	
Adolescent Well-Care Visits	65.84	90	6	
Weight Assessment/Adolescents: BMI % Total	79.9	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation Phase	44.38	25	3	3.25
Antidepressant Medication Management Effective Continuation Phase Treatment	29.82	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	40.26	50	4	
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	65.19	75	5	

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
Follow Up After Emergency Department Visits for Mental Illness- 7 Day Total	42.20	90	6	
Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation Total	38.61	25	3	

Performance Improvement Project Validation

Select Health submitted two projects for validation – Diabetes Outcomes Measures and Well Care Visits for Foster Care Population. *Table 3: Performance Improvement Project Validation Scores* provides an overview of the previous validation scores with the current scores. All PIPs scored in the "High Confidence in Reported Results" range.

Table 3: Performance Improvement Project Validation Scores

Project	Previous Validation Score	Current Validation Score
Diabetes Outcomes Measures	110/111=99% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results
Well Care Visits for Foster Care Population	PIP not active in 2019	83/83=100% High Confidence in Reported Results

The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year. The report noted COVID as a barrier to obtaining the records, which impacted the rates. The Well Child Visits PIP reported the baseline year as 2020 and other year's rates were included to gather trends for the HEDIS based measures.

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)

The Utilization Management (UM) Program Description 2020 outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. Policies and procedures define how services are implemented and provided to members.

Appropriate reviewers conduct service authorization requests using internal clinical guidelines or other established criteria. The Care Management (CM) Program Description

and policies appropriately document care management processes and services provided. However, there are documentation issues noted related to appeals and the CM program where contract requirements were omitted.

Overall, the review of UM approval, appeals, and denial files provided evidence that appropriate processes are followed, Case Management files indicate care gaps are identified and addressed consistently and services are provided for various risk levels.

Delegation:

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

CCME's review of delegation functions examined the submitted Delegate List, delegation contracts, and delegation monitoring materials. Select Health reported 11 current delegation agreements. Monitoring of these delegates occurs annually. Select Health provided a copy of the Credentialing and Recredentialing file review tools 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 nurse practitioners, as required in Exhibit B of Policy CP 210.107.

State Mandated Services:

42 CFR § Part 441, Subpart B

Select Health's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program follows the Bright Futures Periodicity Schedule for required screenings and health treatments. Select Health monitors provider compliance with provision of EPSDT services and required immunizations through HEDIS requirements and medical record reviews conducted by the Quality Department. The 2019 Quality Improvement Program Evaluation identified EPSDT performance measures below established benchmarks.

Select Health provides all core benefits specified by the *SCDHHS Contract*.

During the current EQR, CCME noted incorrect documentation of provider network geographic access standards in the Select Health of South Carolina Availability of Practitioners Report. This is a repeat finding from the previous EQR.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were 2 standards scored as "Partially Met" and no standards scored as "Not Met". Following the 2019 EQR, Select Health submitted a Quality Improvement Plan to address any deficiencies identified. CCME reviewed and

accepted the Quality Improvement Plan on January 14, 2020. The following is a high-level summary of those deficiencies:

- The parameters for measuring compliance with routine appointment access did not meet the SCDHHS Contract requirements.
- The monitoring for one delegate did not include the Inner-Rater – Reliability studies and results.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies. CCME noted incorrect documentation of provider network geographic access standards in the Select Health of South Carolina Availability of Practitioners Report. This is a repeat finding from the previous EQR. Select Health indicated a written policy would be created regarding its monitoring and auditing activities to ensure there is a formal documented process for addressing EQR identified deficiencies.

Table 4, Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2019 review. 206 out of 214 standards received a score of "Met". There were four standards scored as "Partially Met" and four standards received a "Not Met" score.

Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2019	40	0	0	0	0	40	100%
2020	40	0	0	0	0	40	100%
Provider Services							
2019	77	1	0	0	0	78	99%
2020	72	1	3	0	0	76	95%
Member Services							
2019	33	0	0	0	0	33	100%
2020	32	1	0	0	0	33	97%
Quality Improvement							
2019	14	0	0	0	0	14	100%
2020	14	0	0	0	0	14	100%
Utilization							
2019	45	0	0	0	0	45	100%

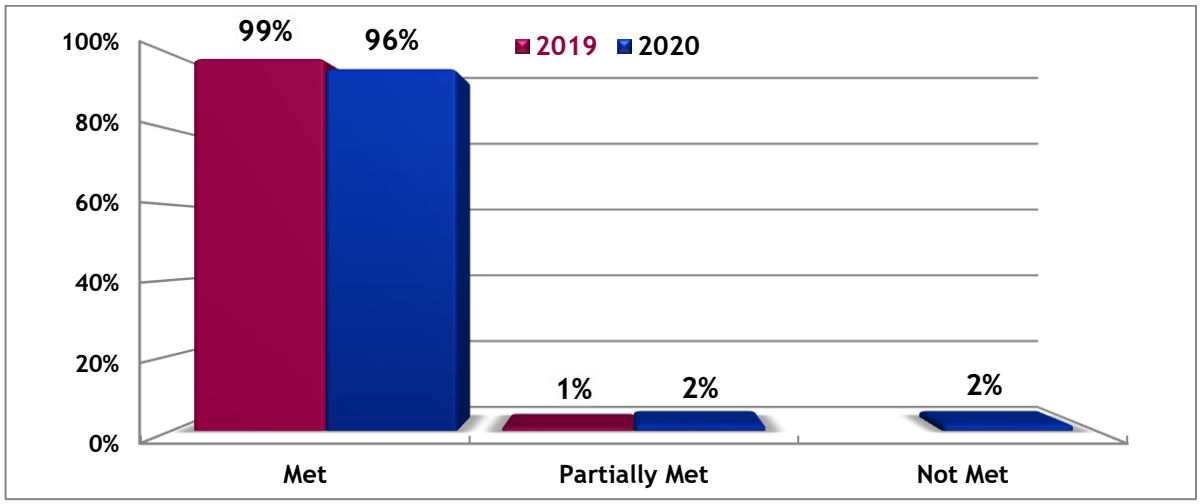
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2020	44	1	0	0	0	45	98%
Delegation							
2019	1	1	0	0	0	2	50%
2020	1	1	0	0	0	2	50%
State Mandated Services							
2019	4	0	0	0	0	4	100%
2020	3	0	1	0	0	4	75%
Totals							
2019	**214**	**2**	**0**	**0**	**0**	**216**	**99%**
2020	**206**	**4**	**4**	**0**	**0**	**214**	**96%**

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

Conclusions

Overall, Select Health met 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*. The 2020 Annual EQR shows that Select Health has achieved a "Met" score in 96% of the standards reviewed. As the following chart indicates, 2% of the standards were scored as "Partially Met," and 2% of the standards scored as "Not Met". The chart that follows provides a comparison of the current review results to the 2019 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

The following is a summary of key findings and recommendations or opportunities for improvements.

- Select Health's disaster recovery tests stand out because the organization performs actual remote location disaster recovery testing while many organizations perform abbreviated tabletop recovery exercises.
- Select Health has revised methods for provider education in response to restrictions from COVID-19, including frequent telephonic contact, virtual training sessions, increased written communication (such as provider alerts and newsletters), and a dedicated section of the website for COVID-19.
- Deficiencies noted in initial credentialing files.
- The standards used to measure member access for internal medicine providers and some specialty providers was incorrect.
- The Select Health of South Carolina Accessibility of Services Report indicates specialty providers were measured for accessibility using an appointment access timeframe of six to eight weeks for routine care. This is inconsistent with the timeframe of four to 12 weeks documented in Policy NM 159.203. This is repeat finding from the previous year's EQR.
- 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 dropped slightly from last year's rate of 81%.
- Select Health provides relevant member education in newsletters like COVID-19 guidelines and hurricane-preparedness information.
- The First Choice by Select Health YouTube channel provides wellness demonstration videos for members.
- Member Satisfaction Survey response rates were lower than the NCQA target of 40%.
- The HEDIS rate for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis - Total increased 19.78%.
- The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year.
- Requirements for Targeted Case Management Services are not included in the program description or in policies.
- A deficiency noted in the previous EQR related to documentation of provider network geographic access standards in annual reporting documents was noted again in the current EQR.

Recommendations and Opportunities for Improvements

Areas needing corrections and recommendations include:

- Ensure all initial credentialing files contain evidence of querying the Social Security Administration's Death Master File. Also, ensure the 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.
- 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 four to 12 weeks for routine specialty appointments. Refer to the *SCDHHS Contract, Section 6.2.3.1.5.3.*
- *Ensure geographic access reports are run using the contractually required standards for internal medicine and specialty providers.*
- Set a plan for the provider network management workgroup to review records to ensure provider contact information is updated and initiate new interventions to update provider information.
- Continue interventions for the Diabetes Outcomes PIP to improve rates by addressing patient and provider barriers. Continue working on ways to mitigate the impact of COVID-19 on data collection and data retrieval.
- Include the requirements for TCM services in a policy or other documents, as noted in *SCDHH Contract Section 4.2.27.*
- Ensure all deficiencies identified during the EQR process are addressed with actions to correct the deficiency and prevent recurrence.

METHODOLOGY

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

On September 11, 2020, CCME notified Select Health that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow 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 25, 2020 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. CCME also conducted a review of credentialing, grievance, utilization, case management, and appeal files during the desk review.

The second segment was a two-day, onsite teleconference conducted on November 11, 2020 and November 12, 2020 via WebEx due to issues with COVID-19. The onsite teleconference focused on areas not covered by the desk review and areas needing clarification (see *Attachment 2*). CCME's onsite teleconference activities included the following:

- Entrance and exit conferences (open to all interested parties)
- Interviews with Select Health's administration and staff

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 for Select Health focuses on policies and procedures, staffing, information systems, compliance, program integrity, and confidentiality.

First Choice by Select Health is a subsidiary of AmeriHealth Caritas. Market President Courtnay Thompson leads overall operations for Select Health. Sean Popson is Director, Plan Operations and Administration, and is responsible for the day-to-day direction, management, and coordination of business planning and administrative functions. The Market Chief Medical Officer, Dr. Kirt Caton, is board certified in family medicine and is responsible for clinical leadership and execution of all health care affordability and clinical quality initiatives. Dr. Kathleen Domm is the Medical Director for Foster Care. Additional corporate Medical Directors include Dr. Cathryn Caton, Dr. Natasha Choyah, Dr. Melissa Pearce, and Dr. Courtney Jones. Michelle Cooke, Psy.D., serves as the Medical Director for Behavioral Health services.

An established process is in place for policy and procedure maintenance, including annual review of all policies and revision as needed. Policies and procedures are housed on a shared internal drive for staff access. New employees review existing policies and procedures during orientation, and all staff are expected to read new and revised policies within a reasonable timeframe of implementation.

Select Health's Information Systems Capabilities Assessment (ISCA) documentation demonstrates the organization is committed to the fundamentals of data security (confidentiality, integrity, and availability). The focus on data confidentiality is reflected in the company's policies and procedures. The emphasis on data integrity and availability is reflected in its disaster recovery (DR) plan. The DR plan was tested and successfully completed within the allotted recovery timeframe. Select Health's DR tests stand out because the organization performs actual remote location disaster recovery testing while many organizations only perform abbreviated tabletop recovery exercises.

The Select Health 2020 Compliance Plan and Program Integrity Plan define standards, describe methods for monitoring those standards, and identify corrective action processes to guard against fraud, waste, and abuse (FWA). Select Health has established policies and procedures as well as the Code of Conduct, Ethics, and Disciplinary Action to maintain, monitor, and enforce quality services consistently on an organization-wide basis.

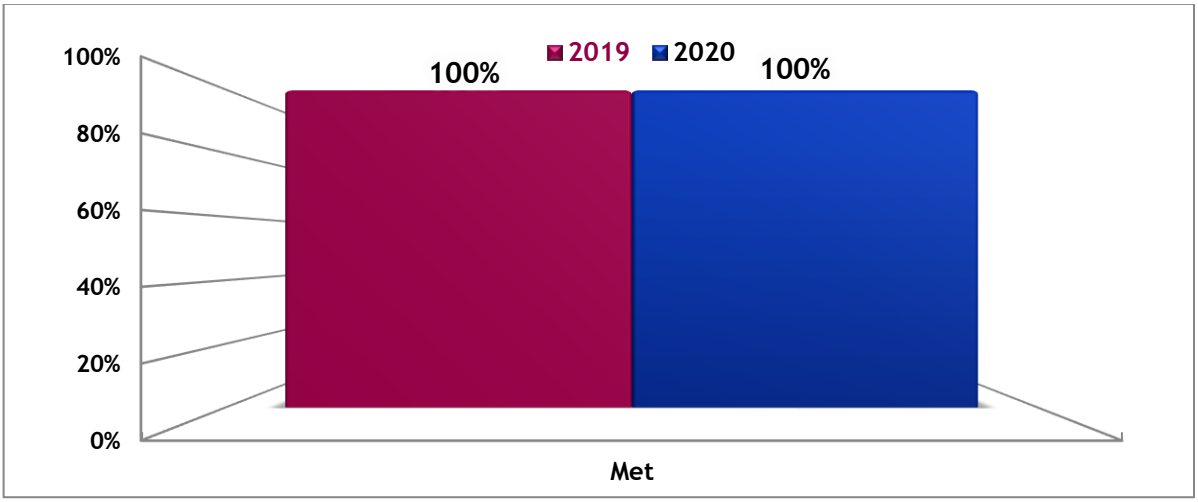
Select Health implements guidelines by the Office of the Inspector General regarding effective lines of communication with oversight provided by the Compliance Officer and

the Compliance and Privacy Committee. Internal monitoring of reported or suspected FWA is completed via collaborative effort that includes the Special Investigation Unit and the Data Mining Team. The Compliance Department conducts timely, reasonable inquiries into any incident where evidence suggests there has been misconduct related to payment or service delivery.

Select Health has established policies specific to confidentiality, which stipulate that all Company associates, during the course of business operations, have a responsibility for the use and disclosure of member Protected Health Information. That information is regulated pursuant to the Health Insurance Portability and Accountability Act (HIPAA). The 2020/2021 Confidentiality, Privacy, and Security Agreement Statement is accessible electronically, and all AmeriHealth Caritas Family of Companies associates are required to sign the statement. Select Health conducts and evaluates training on fraud, waste, and abuse for all aspects of Compliance, Program Integrity, and Confidentiality annually and for new employees. The training is available for review by stakeholders on the Select Health website.

As noted in *Figure 2: Administration Findings*, Select Health achieved a score of "Met" for 100% of the standards in the Administration section of the review.

Figure 2: Administration Findings



Strengths

- Select Health has an organization-wide security policy that establishes an overall security protocol for the company and individual security policies that detail each facet of the organization's security measures. Timestamps indicate the organization frequently reviews and updates its policy documents.

- Select Health's disaster recovery tests stand out because the organization performs actual remote location disaster recovery testing while many organizations perform abbreviated tabletop recovery exercises.
- Select Health maintains the Health Care Professional and Provider Manual and online platforms that include examples of fraud, waste and abuse, which are easily understandable for stakeholders from multiple perspectives (i.e. billing discrepancies, prescription issues, and service provision practices), and provide clear, anonymous reporting options.

Weaknesses

- The Organizational Chart indicates Nicole Rosenblum is Interim Compliance Officer; however, onsite discussion confirmed Manuel Mendizabal is Compliance Officer.
- The Organizational Chart does not indicate the line of reporting for the Manager, Rapid Response Outreach Team.
- The Program Integrity Plan does not identify the process of monitoring the Social Security Death Master File.

Recommendations

- Ensure the Organizational Chart correctly reflects current staffing.
- Revise the organizational chart to display the line of reporting for the Manager, Rapid Response Outreach Team.
- Revise the Program Integrity Plan to outline steps being taken to monitor the Social Security Administration's Death Master File.

B. Provider Services

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

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

Provider Credentialing and Selection

The Select Health of South Carolina Credentialing Program 2020 and associated policies document the processes and requirements for initial credentialing and recredentialing of providers for inclusion in Select Health's network. Additional policies cover topics including ongoing monitoring for licensure and Medicare/Medicaid sanctions, maintaining confidentiality of provider credentialing information, actions and reporting related to

provider quality, and the processes for appeals related to provider credentialing determinations.

Membership of Select Health's Credentialing Committee, a subcommittee of the Quality Assessment Performance Improvement Committee, includes internal plan management, staff, and participating external providers with specialties including family practice, internal medicine, pediatrics, obstetrics & gynecology, and behavioral health. The committee meets monthly and is chaired by the Market Chief Medical Officer. Onsite discussion confirmed attempts to recruit mid-level clinicians to become members of the committee; although unsuccessful to date, the efforts continue. Credentialing Committee minutes reflected the presence of a quorum for each meeting and detailed discussion of provider files prior to making credentialing/recredentialing determinations.

Credentialing and recredentialing files were well organized, and most required information was included. However, CCME identified a few issues in the files related to queries of the Social Security Administration's Death Master File (initial credentialing files) and primary source verification of the providers' Clinical Laboratory Improvement Amendment (CLIA) Certificates (recredentialing files). These issues are discussed in detail in the "Weaknesses" section that follows.

Availability of Services

Policy NM 159.206, Availability of Practitioners, defines the geographic access standards for primary care providers (PCPs) and specialists. The Select Health of South Carolina Availability of Practitioners Report, page one, indicates the standard for urban/suburban internal medicine providers is two providers within 20 miles; this is inconsistent with the standard defined in Policy NM 159.206. Also, the Select Health of South Carolina Availability of Practitioners report defines urban/suburban access standards for cardiology, optometry, and otolaryngology as one provider within 50 miles, which is also inconsistent with the standard defined in Policy NM 159.206. These discrepancies were discussed, and Select Health staff responded that, although the report contained typographical errors in the standards, the results are accurate and meet the standards in the policy. They also stated the report will be corrected.

Select Health conducts an annual analysis to measure performance against standards for appointment access. Data include findings from network accessibility reporting, member grievances and appeals, CAHPS results, and an annual after-hours survey of all PCP locations. The Select Health of South Carolina Accessibility of Services Report indicates the goal of 90% was exceeded for after-hours access to PCPs, appointment access for routine and urgent PCP care, and most specialty appointment access categories. The goal was not met for urban otolaryngology (high volume and high impact) and rural allergy (high volume). However, the Select Health of South Carolina Accessibility of Services

Report indicates specialty providers were measured using an appointment access timeframe of six to eight weeks for routine care. This timeframe is inconsistent with Policy NM 159.203 and represents a repeat finding from the previous year's EQR.

Select Health's Provider Network Management staff conducts initial training within 30 calendar days of placing a newly contracted provider or provider group on active status. Ongoing training is conducted as needed to ensure compliance with program standards. Select Health staff discussed changes that have been implemented for provider education in response to restrictions from COVID-19. These include frequent telephonic contact, virtual training sessions, increased written communication (such as provider alerts and newsletters), and a dedicated section of the website for COVID-19.

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, CCME conducted a provider access study 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 identified. 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 contracted providers.

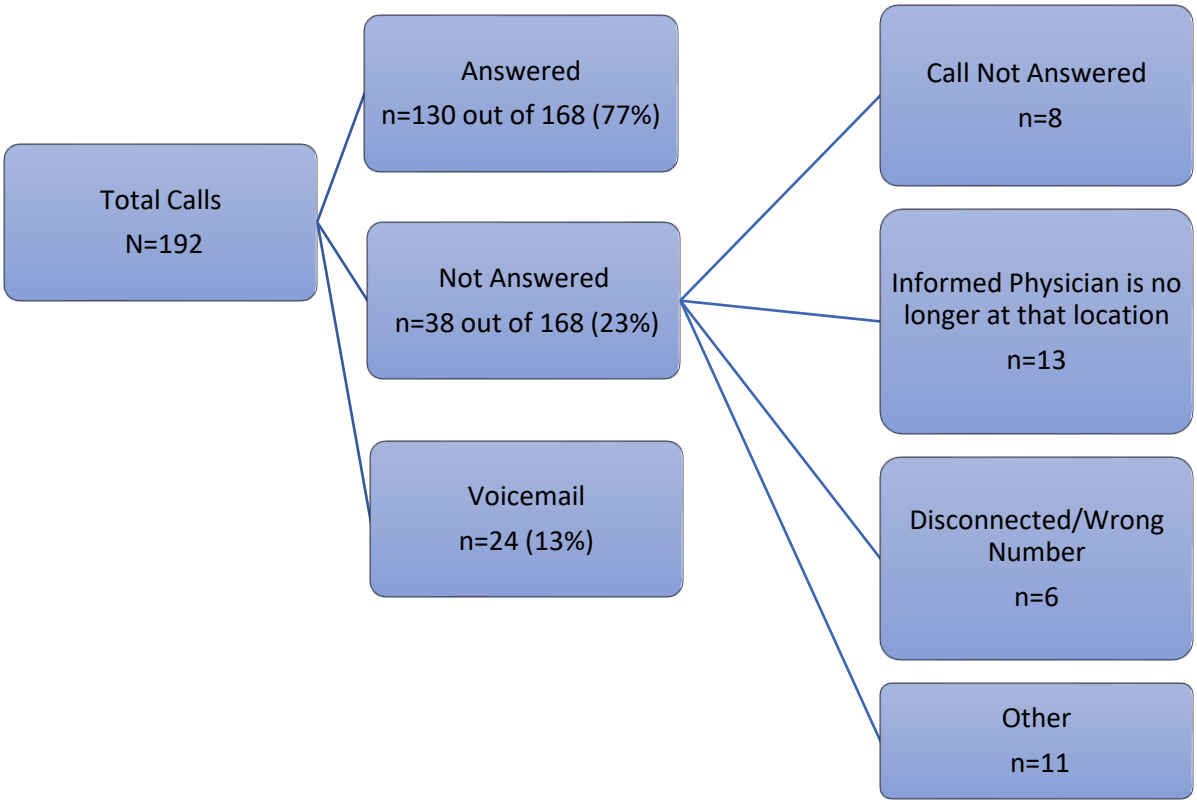
Calls were successfully answered 77% of the time (130 of 168) when omitting calls answered by personal or general voicemail messaging services (see *Table 5* below). The success rate dropped slightly from last year's rate of 81%.

Table 5: Provider Access Study Results for Current and Previous Review Cycle

Review Year	Sample Size	Answer Rate	p-value
2019 Review	238	81% (163 out of 201)	.520
2020 Review	192	77% (130 out of 168)	

When compared to last year's results of 81%, this year's study rate of 77% was not a statistically significant decrease in successful calls (p=.520). *Figure 3: Telephonic Provider Access Study Results* provides an overview of the results of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



For the calls not answered successfully (n=38 calls), 13 (34%) were because the physician was no longer active at that location.

Of the 130 successful calls, 77 providers answered the question regarding whether they accepted Select Health. Of the 77 providers, 71 (92%) responded "Yes," four (5%) responded "No," and two (3%) responded "Under Certain Conditions." Of the 71 who are accepting Select Health, 55 (77%) are accepting new patients, and 16 (23%) are not accepting new patients.

Of the 60 providers that answered the question about prescreening, 28 (47%) do not require prescreening, and 32 (53%) do require prescreening. Of the 32 that require prescreening, 20 (63%) require both an application and medical record review, two (6%) require a medical record review only, and 10 (31%) require another type of screening such as information on insurance card and medical history review.

Select Health achieved "Met" scores for 95% of the Provider Services standards, as illustrated in *Figure 4: Provider Services Findings*.

Figure 4: Provider Services Findings

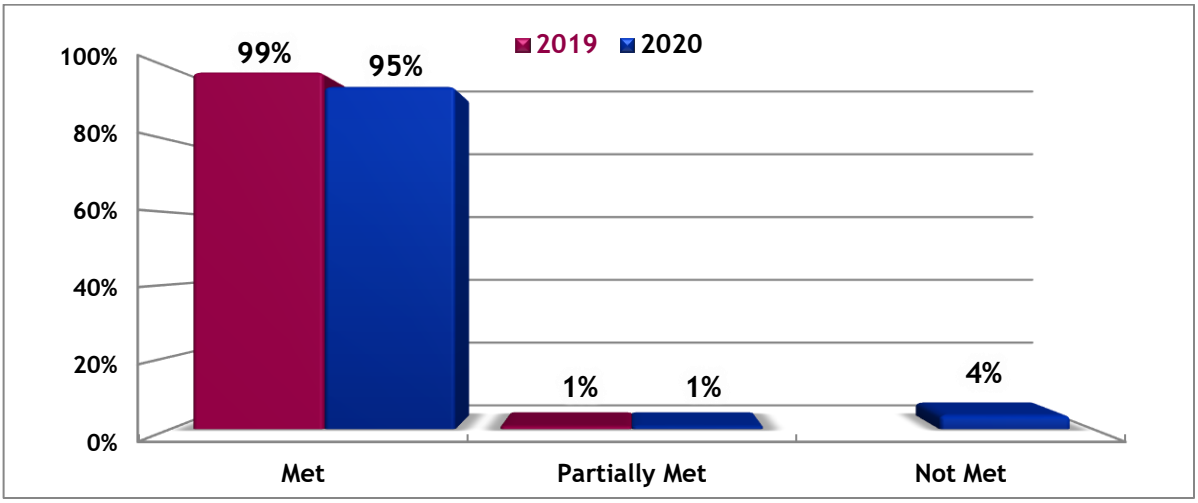


Table 6: Provider Services Comparative Data

Section	Standard	2019 Review	2020 Review
Credentialing and Recredentialing	(Initial Credentialing) Verification of information on the applicant, including: Query of Social Security Administration's Death Master File (SSDMF)	Met	Partially Met
	(Recredentialing) Verification of information on the applicant, including: Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Not Met
Adequacy of the Provider Network	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Not Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Select Health has been awarded the Multicultural Health Care Distinction by the National Committee for Quality Assurance multiple times, most recently in 2019.
- Select Health has revised methods for provider education in response to restrictions from COVID-19, including frequent telephonic contact, virtual training sessions, increased written communication (such as provider alerts and newsletters), and a dedicated section of the website for COVID-19.

Weaknesses

- Deficiencies noted in initial credentialing files include:
  - One file was missing evidence of query of the Social Security Administration's Death Master File.
  - Three 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.
- Nine of 16 recredentialing files had issues with primary source verification (PSV) of the providers' CLIA Certificates or Certificates of Waiver including the following (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.
  - In six files, the PSV of the CLIA occurred more than 120 days prior to the recredentialing decision date. 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.
- Table 1 on page one of the Select Health of South Carolina Availability of Practitioners Report indicates the geographic access standard for urban/suburban internal medicine providers is two providers within 20 miles. This is inconsistent with Policy NM 159.206, which defines the standard as one provider within 30 miles (urban/ suburban).
- The Select Health of South Carolina Availability of Practitioners Report defines urban/suburban geographic access standards for cardiology, optometry, and otolaryngology as one provider within 50 miles. This is inconsistent with the geographic access standards for these provider types listed in Policy NM 159.206, Availability of Practitioners, which defines the urban/suburban geographic access requirement as one provider within 30 miles.
- The Select Health of South Carolina Accessibility of Services Report indicates specialty providers were measured for accessibility using an appointment access timeframe of

six to eight weeks for routine care. This is inconsistent with the timeframe of four to 12 weeks documented in Policy NM 159.203. This is repeat finding from the previous year's EQR.

- 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 dropped slightly from last year's rate of 81%.

Quality Improvement Plans

- 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.
- 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.
- 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 four to 12 weeks for routine specialty appointments. Refer to the *SCDHHS Contract, Section 6.2.3.1.5.3.*
- Set a plan for the provider network management workgroup to review records to ensure provider contact information is updated and initiate new interventions to update provider information.

Recommendations

- Ensure geographic access reports are run using the contractually required standards for internal medicine providers listed in Policy NM 159.206 and in the *Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* Also, ensure results documented in the Select Health of South Carolina Availability of Practitioners Report correspond to those standards.
- Ensure geographic access reports are run using the contractually required standards for specialty provider types listed in Policy NM 159.206, the *SCDHHS Contract, Section 6.2.3.1.4*, and in the *Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* Also, ensure results documented in the Select Health of South Carolina Availability of Practitioners Report correspond to those standards.

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

Select Health's Member Services review focused on areas such as member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures and files.

Select Health has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. The Member Handbook provides useful information, is easily understood and is written at a sixth-grade reading level. The Member Handbook instructs members how to access benefits and informs them of their rights and responsibilities, preventive health guidelines, and appointment guidelines.

The New Member Packet includes resources such as the Quick Start Guide, Co-Payment Reference Guide, and a Welcome Letter with instructions for accessing the Member Handbook and the Provider Directory online. All members have access to information and resources in the Member Handbook, in the Provider Manual, on the website, and in member newsletters that assist them with accessing their benefits.

During the onsite teleconference, staff reported new members receive a New Member Packet within 14 days of enrollment. CCME identified a documentation error in Policy MEM 129.107, New Member Orientation Calls, that states New Member Packets are sent within 30 days of enrollment notification and Member ID Cards are sent within 15 days. Additionally, Policy MEM 129.124, Member Requested Print Material, incorrectly notes members will receive a copy of the Member Handbook upon enrollment.

The plan provides information on preventive health guidelines and encourages members to obtain recommended preventive services. Health and wellness topics related to behavioral health, childhood obesity, and well visits are posted to the member website, as is the Healthy Now member newsletter. Select Health ensures member program materials are written in a clear and understandable manner and meet contractual requirements. Discussions confirmed member materials are made available in alternative formats, standard materials are printed in 12-point font, and taglines and materials requiring large print are completed in 18-point font.

Member Services staff are in South Carolina and available during the hours of 8 a.m. to 9 p.m. EST Monday through Friday and 8 a.m. to 6 p.m. EST Saturday and Sunday. The toll-free number routes callers to an Interactive Voice Response menu that allows callers to reach correct staff. The Nurse Call Line is available 24 hours a day.

Select Health contracts with SPH Analytics, a CAHPS Survey vendor, to conduct the child and adult surveys.

Although 2020 surveys were not validated, it is noted that the response rate declined for the child survey from 22% in 2019 to 15.3% in 2020, and the child with chronic conditions (CCC) survey response rate declined from 22% in 2019 to 15% in 2020. However, the adult survey response rate improved from 17% in 2019 to 19.2% in 2020. Overall, response rates were below the National Committee for Quality Assurance (NCQA) target of 40%.

Grievances

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

Requirements and processes for handling member grievances and complaints are found in policies, and information is provided in the Member Handbook, Provider Manual, and the website. However, CCME identified that these areas need additional instructions for members who choose to file a written grievance, such as providing name, address, ID number, or signed consent. Grievance files reflect timely acknowledgement, resolution, and review by appropriate staff.

As noted in *Figure 5: Member Services Findings*, Select Health received "Met" scores for 97% of the standards and "Partially Met" scores for 3% of the standards.

Figure 5: Member Services Findings

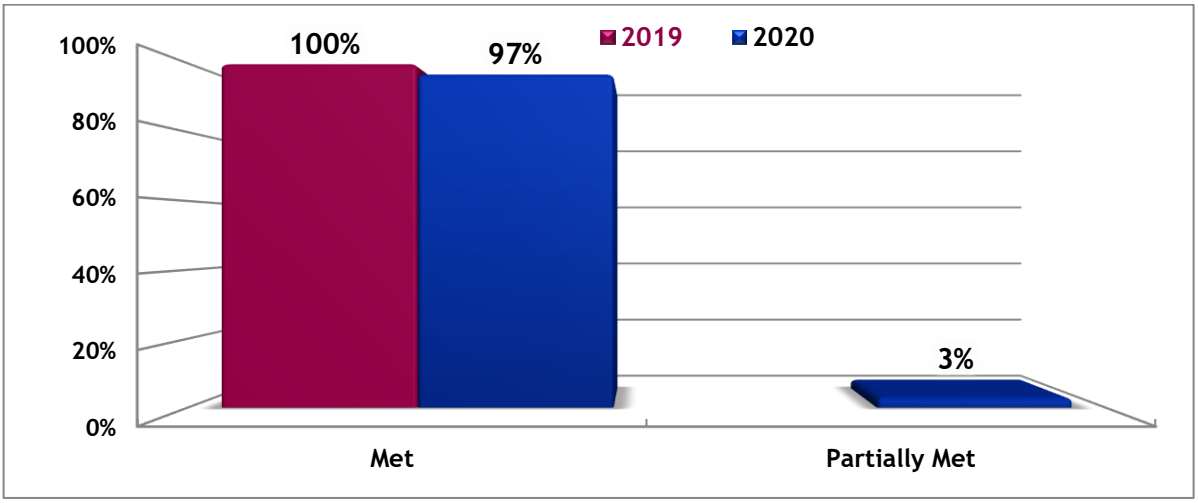


Table 7: Member Services Comparative Data

Section	Standard	2019 Review	2020 Review
Member MCO Program Education	Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- Grievance resolution letters are easy to understand, address the member's concerns, and clearly state the resolution outcome.
- Select Health provides relevant member education in newsletters like COVID-19 guidelines and hurricane-preparedness information.
- The First Choice by Select Health YouTube channel provides wellness demonstration videos for members.

Weaknesses

- Policy MEM 129.107, New Member Orientation Calls, incorrectly states that a new member is mailed the First Choice New Member Packet within 30 days of enrollment notification and a Member ID Card within 15 days.
- Policy MEM 129.124, Member Requested Print Material, incorrectly notes a member will receive a copy of the Member Handbook upon enrollment.
- Member Satisfaction Survey response rates were lower than the NCQA target of 40%.
- Policy MMS.100, Member Grievances and Appeals Process, the Member Handbook, and website do not provide the necessary information for members to include when filing a written grievance such as name, address, or signed consent, if appropriate.
- The full requirement for Select Health to give prompt oral notice and inform the enrollee of the right to file a grievance when Select Health requests a grievance extension is omitted from the Member Handbook.

Quality Improvement Plans

- 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 *SCDHHS Contract, Section 3.14.3.*

Recommendations

- Correct Policy MEM 129.124, Member Requested Print Material, to reflect a member will not receive a paper copy of the Member Handbook upon enrollment.
- Continue working with SPH Analytics to increase response rates for the child, child with chronic conditions, and adult surveys.
- Include additional grievance instructions in Policy MMS.100, Member Grievances and Appeals Process, in the Member Handbook, and on the website that specify all necessary information required when filing a written grievance.
- Edit the Member Handbook to include the complete requirement applicable when Select Health requests a grievance extension. Refer to the *SCDHHS Contract, Section 9.1.6.1.5.1 through 9.1.6.1.5.2.*

D. Quality Improvement

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

For the Quality Improvement (QI) section, CCME reviewed the Quality Improvement Program Description 2020, committee structure and minutes, performance measures, performance improvement projects, and the Quality Improvement Program Evaluation 2020. Select Health's 2020 QI Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.

Select Health's QI work plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 work plans included the planned activity/deliverable, purpose/scope, target dates for completions, responsible party, and department. The annual work plan is developed by the Quality Management Department and forwarded to the Quality Assessment and Improvement Committee for review and approval.

The Quality Assessment Performance Improvement Committee (QAPIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The committee charter clearly outlines the responsibilities of the QAPIC. Minutes are recorded for each meeting and document committee discussion points and decisions. The minutes provided with the desk materials indicated the required quorum was met for each meeting. The QAPIC is chaired by the Market President. Other members of the committee include senior leaders, department directors, and other health plan staff. According to the committee charter, three to six network providers are included as voting members of this committee. However, only two providers were listed on the committee membership list. Staff indicated there were issues getting network

providers to participate in the committee meetings. Recruiting for new network providers is ongoing.

The Quality Clinical Care Committee is a subcommittee of the QAPIC. This committee is responsible for monitoring clinical care services and outcomes. The committee is chaired by the Chief Medical Officer. Voting members of the committee include four practicing primary care practitioner and specialists. However, the membership list and committee minutes included only three practitioners. The meeting frequency is noted as bi-monthly or at least five times a year. For this EQR, the committee only met in November 2019 and January 2020. The March, May, and July 2020 meetings were canceled. Disbanding this committee was discussed with the QAPIC. Select Health indicated the decision was to continue with the Quality of Clinical Care Committee and eliminate some of the duplication between the QAPIC and the Quality of Clinical Care Committee.

Annually, Select Health evaluates the overall effectiveness of the QI Program and reports this evaluation to the QAPIC for review and recommendations. The Quality Improvement Program Evaluation 2019 addressed all aspects of the QI Program.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (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.

Table 8: HEDIS Performance Measure Results reports all relevant HEDIS performance measures for Select Health for the current review year, measure year (MY) 2019, the previous year (MY 2018), and the change from 2018 to 2019. The change in rates shown in green indicates a substantial (>10%) improvement, and the rates shown in red indicate substantial (>10%) decline.

Table 8: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	87.44%	87.76%	0.32%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	79.90%	79.90%	--
Counseling for Nutrition	64.07%	64.07%	--

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
Counseling for Physical Activity	59.30%	59.30%	--
Childhood Immunization Status (cis)			
DTaP	77.62%	77.62%	--
IPV	92.46%	92.46%	--
MMR	88.56%	88.56%	--
HiB	85.40%	85.40%	--
Hepatitis B	91.97%	91.97%	--
VZV	88.32%	88.32%	--
Pneumococcal Conjugate	82.97%	82.97%	--
Hepatitis A	84.43%	84.43%	--
Rotavirus	78.59%	78.59%	--
Influenza	38.69%	38.69%	--
Combination #2	74.21%	74.21%	--
Combination #3	72.51%	72.51%	--
Combination #4	70.56%	70.56%	--
Combination #5	63.50%	63.50%	--
Combination #6	34.31%	34.31%	--
Combination #7	62.53%	62.53%	--
Combination #8	34.31%	34.31%	--
Combination #9	31.39%	31.39%	--
Combination #10	31.39%	31.39%	--
Immunizations for Adolescents (ima)			
Meningococcal	76.40%	76.40%	--
Tdap/Td	89.54%	89.54%	--
Combination #1	75.43%	75.43%	--
Human Papillomavirus Vaccine for Female Adolescents (hpv)	34.06%	34.06%	--
Lead Screening in Children (lsc)	76.32%	76.32%	--
Breast Cancer Screening (bcs)	60.56%	60.49%	--
Cervical Cancer Screening (ccs)	68.71%	68.71%	--
Chlamydia Screening in Women (chl)			
16-20 Years	57.09%	58.16%	1.07%
21-24 Years	64.76%	66.09%	1.33%
Total	59.05%	59.98%	0.93%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	NA	86.21%	NA
18-64 years	NA	75.13%	NA

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
65+ years	NA	NA	NA
Total	84.10%	84.49%	0.39%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	30.92%	32.96%	0.39%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	62.92%	64.04%	1.12%
Bronchodilator	79.50%	83.87%	4.37%
Medication Management for People with Asthma (mma)			
5-11 Years - Medication Compliance 50%	61.29%	63.62%	2.33%
5-11 Years - Medication Compliance 75%	34.01%	35.72%	1.71%
12-18 Years - Medication Compliance 50%	60.27%	59.47%	-0.80%
12-18 Years - Medication Compliance 75%	32.92%	33.77%	0.85%
19-50 Years - Medication Compliance 50%	59.62%	58.26%	-1.36%
19-50 Years - Medication Compliance 75%	33.70%	37.76%	4.06%
51-64 Years - Medication Compliance 50%	75.00%	70.71%	-4.29%
51-64 Years - Medication Compliance 75%	53.03%	50.71%	-2.32%
Total - Medication Compliance 50%	61.03%	61.56%	0.53%
Total - Medication Compliance 75%	33.98%	35.50%	1.52%
Asthma Medication Ratio (amr)			
5-11 Years	75.76%	74.10%	-1.66%
12-18 Years	66.96%	64.19%	-2.77%
19-50 Years	56.27%	56.11%	-0.16%
51-64 Years	59.77%	47.15%	-12.62%
Total	69.72%	67.28%	-2.44%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	60.10%	60.10%	--
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	78.31%	77.66%	-0.65%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	77.28%	78.25%	0.97%
Statin Adherence 80% - 21-75 years (Male)	58.78%	60.70%	1.92%
Received Statin Therapy - 40-75 years (Female)	75.12%	76.90%	1.78%
Statin Adherence 80% - 40-75 years (Female)	51.13%	54.49%	3.36%
Received Statin Therapy - Total	76.16%	77.56%	1.40%
Statin Adherence 80% - Total	54.86%	57.55%	2.69%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	89.35%	89.35%	--

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
HbA1c Poor Control (>9.0%)	46.03%	46.03%	--
HbA1c Control (<8.0%)	43.50%	43.50%	--
HbA1c Control (<7.0%)	29.20%	29.20%	--
Eye Exam (Retinal) Performed	55.42%	55.42%	--
Medical Attention for Nephropathy	91.16%	91.16%	--
Blood Pressure Control (<140/90 mm Hg)	60.29%	60.29%	--
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	60.58%	60.72%	0.14%
Statin Adherence 80%	50.94%	53.12%	2.18%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in	70.42%	NR	NR
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	44.86%	45.52%	0.66%
Effective Continuation Phase Treatment	29.55%	29.82%	0.27%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	39.38%	44.38%	5.00%
Continuation and Maintenance Phase	52.65%	56.88%	4.23%
Follow-Up After Emergency Department Visit for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	72.92%	74.62%	1.70%
6-17 years - 7-Day Follow-Up	43.73%	48.99%	5.26%
18-64 years - 30-Day Follow-Up	54.53%	57.21%	2.68%
18-64 years - 7-Day Follow-Up	29.66%	33.41%	3.75%
65+ years - 30-Day Follow-Up	NR*	NR*	NA
65+ years - 7-Day Follow-Up	NR*	NR*	NA
30-Day Follow-Up	63.38%	67.03%	3.65%
7-Day Follow-Up	36.43%	42.20%	5.77%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	72.43%	73.95%	1.52%
6-17 years - 7-Day Follow-Up	50.73%	56.91%	6.18%
18-64 years - 30-Day Follow-Up	49.67%	51.31%	1.64%
18-64 years - 7-Day Follow-Up	34.25%	36.27%	2.02%
65+ years - 30-Day Follow-Up	NR*	NR*	NA
65+ years - 7-Day Follow-Up	NR*	NR*	NA
30-Day Follow-Up	63.78%	65.76%	1.98%
7-Day Follow-Up	44.46%	49.45%	4.99%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
13-17 years - 30-Day Follow-Up	NA	54.17%	NA
13-17 years - 7-Day Follow-Up	NA	29.17%	NA

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
18-64 years - 30-Day Follow-Up	NA	39.41%	NA
18-64 years - 7-Day Follow-Up	NA	28.82%	NA
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
Total - 30-Day Follow-Up	NA	40.38%	NA
Total - 7-Day Follow-Up	NA	28.85%	NA
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years	10.68%	11.00%	0.32%
7-Day Follow-Up: 13-17 Years	4.85%	3.00%	-1.85%
30-Day Follow-Up: 18+ Years	19.80%	16.59%	-3.21%
7-Day Follow-Up: 18+ Years	14.04%	12.26%	-1.78%
30-Day Follow-Up: Total	18.76%	15.86%	-2.90%
7-Day Follow-Up: Total	12.99%	11.05%	-1.94%
Diabetes Screening for People with Schizophrenia or Bipolar	78.67%	80.26%	1.59%
Diabetes Monitoring for People with Diabetes and	69.23%	71.11%	1.88%
Cardiovascular Monitoring for People with Cardiovascular	75.00%*	83.33%*	8.33%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	NA	25.35%	NA
65+ years	NA	0.00%*	NA
Total	NA	25.30%	NA
Adherence to Antipsychotic Medications for Individual with Schizophrenia (saa)	67.47%	66.43%	-1.04%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	NA	50.30%	NA
Cholesterol Testing - 1-11 Years	NA	39.24%	NA
Blood glucose and Cholesterol Testing - 1-11 Years	NA	36.52%	NA
Blood glucose testing - 12-17 Years	NA	63.00%	NA
Cholesterol Testing - 12-17 Years	NA	44.27%	NA
Blood glucose and Cholesterol Testing - 12-17 Years	NA	42.21%	NA
Blood glucose testing - Total	NA	58.65%	NA
Cholesterol Testing - Total	NA	42.55%	NA
Blood glucose and Cholesterol Testing - Total	NA	40.26%	NA
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	89.70%	NR	NA
Diuretics	89.85%	NR	NA
Total	89.77%	NR	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.81%	0.85%	0.04%

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
Appropriate Treatment for Children with URI (uri)			
3months-17 Years	NA	86.99%	NA
18-64 Years	NA	69.27%	NA
65+ Years	NA*	NA*	NA
Total	86.37%	85.14%	-1.23%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	NA	52.31%	NA
18-64 Years	NA	28.86%	NA
65+ Years	NA	NA	NA
Total	26.03%	45.81%	19.78%
Use of Imaging Studies for Low Back Pain (lbp)	73.17%	74.62%	1.45%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	0.00%	NR	NA
6-11 Years	0.00%	NR	NA
12-17 Years	1.44%	NR	NA
Total	0.95%	NR	NA
Use of Opioids and High Dosage (uod)	3.62%	4.55%	0.93%
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers	25.58%	20.58%	-5.00%
Multiple Pharmacies	14.92%	5.96%	-8.96%
Multiple Prescribers and Multiple Pharmacies	6.51%	3.09%	-3.42%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	4.00%	2.04%	-1.96%
18-64 years - >=31 Days covered	1.61%	1.02%	-0.59%
65+ years - >=15 Days covered	NR*	NA*	NA
65+ years - >=31 Days covered	NR*	NA*	NA
Total - >=15 Days covered	4.00%	2.04%	-1.96%
Total - >=31 Days covered	1.61%	1.02%	-0.59%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	79.79%	79.52%	-0.27%
45-64 Years	89.03%	88.53%	-0.50%
65+ Years	80.00%*	100.00%*	20.00%*
Total	81.99%	81.59%	-0.40%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.55%	97.30%	-0.25%
25 Months - 6 Years	88.74%	89.92%	1.18%
7-11 Years	91.66%	91.95%	0.29%
12-19 Years	90.21%	90.98%	0.77%

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years	38.10%	25.53%	-12.57%
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years	26.67%	5.32%	-21.35%
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	30.43%*	42.11%*	11.68%*
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years*	21.74%*	15.79%	-5.95%
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	35.45%	32.12%	-3.33%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	24.55%	16.13%	-8.42%
Total: Initiation of AOD Treatment: 13-17 Years	35.05%	31.06%	-3.99%
Total: Engagement of AOD Treatment: 13-17 Years	24.02%	15.26%	-8.76%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	39.76%	38.72%	-1.04%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.68%	8.92%	-0.76%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	46.04%	54.30%	8.26%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	25.06%	29.27%	4.21%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	34.65%	36.66%	2.01%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	10.97%	9.94%	-1.03%
Total: Initiation of AOD Treatment: 18+ Years	37.54%	40.16%	2.62%
Total: Engagement of AOD Treatment: 18+ Years	12.92%	13.12%	0.20%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	39.63%	37.75%	-1.88%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	10.99%	8.66%	-2.33%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	45.63%	54.01%	8.38%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	24.97%	28.95%	3.98%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	34.82%	35.56%	0.74%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	13.91%	11.44%	-2.47%
Total: Initiation of AOD Treatment: Total	37.17%	38.61%	1.44%
Total: Engagement of AOD Treatment: Total	14.57%	13.48%	-1.09%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	88.19%	88.19%	--
Postpartum Care	70.83%	70.83%	--
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	NA	65.57%	NA

Measure/Data Element	Measure Year 2018	Measure Year 2019+	Percentage Point Difference
12-17 Years	NA	64.94%	NA
Total	NA	65.19%	NA
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.83%	1.83%	--
1 Visit	0.91%	0.91%	--
2 Visits	3.35%	3.35%	--
3 Visits	2.44%	2.44%	--
4 Visits	4.27%	4.27%	--
5 Visits	8.23%	8.23%	--
6+ Visits	78.96%	78.96%	--
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	76.72%	76.72%	--
Adolescent Well-Care Visits (awc)	65.84%	65.84%	--

NA= Data not available; NR= Not Reported; * indicates small denominator for rate calculation; -- indicates HEDIS 2019 rate used per NCQA allowance; + some hybrid rates reported are MY 2018 per NCQA allowance

Commercial and Medicaid plans reporting to NCQA can report the previous year's data for measures using hybrid methodology only under certain circumstances. NCQA allows a plan to report its audited HEDIS 2019 hybrid rate if the rate is better than its HEDIS 2020 hybrid rate as a result of low chart retrieval. There were several hybrid measures that Select Health chose to report the MY 2018 rate instead of the rate for MY 2019, as allowed by NCQA. Of the rates reported, the HEDIS rate for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) – Total increased 19.78%. The measures that showed a substantial decrease (>10% decrease) in rate were Asthma Medication Ratio (amr) for 51-64-year-olds (decreased by 12.6%), the Initiation and Engagement of AOD Treatment for Alcohol Abuse or Dependence – Initiation (decreased 12.57%), and Engagement (decreased 21.35%).

Quality Withhold Measures

There are 16 quality clinical withhold measures reported for 2019. The Behavioral Health measures are considered Bonus Only for MY 2019 (reporting year 2020). As per the Medicaid Playbook and Managed Care Organizations Policy and Procedure Guide, individual measures within quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 percentile = 1 point; 10-24 percentile = 2 points; 25-49 percentile = 3 points; 50-74 percentile = 4 points; 75-90 percentile = 5 points; >90 percentile = 6 points). Points attained for each measure are multiplied by individual measure's weights then summed to obtain quality index score. *Table 9: Quality*

Withhold Measures shows the 2019 rate, percentile, point value, and index score. The Pediatric Preventive Care rates generated the highest index score, followed by Diabetes, Women's Health and Behavioral Health.

Table 9: Quality Withhold Measures

Measure	MY 2019 Rate	MY 2019 Percentile	Point Value	Index Score
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.35	90	6	4.45
HbA1c Control (< =9)	46.03	25	3	
Eye Exam (Retinal) Performed	55.42	50	4	
Medical Attention for Nephropathy	91.16	50	4	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	88.19	75	5	4.35
Breast Cancer Screen	60.49	50	4	
Cervical Cancer Screen	68.71	75	5	
Chlamydia Screen in Women (Total)	59.98	25	3	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	78.96	90	6	5.30
Well Child Visits in 3rd,4th,5th&6th Years of Life	76.72	75	5	
Adolescent Well-Care Visits	65.84	90	6	
Weight Assessment/Adolescents: BMI % Total	79.9	25	3	
BEHAVIORAL HEALTH				
Follow Up Care for Children Prescribed ADHD Medication- Initiation Phase	44.38	25	3	3.25
Antidepressant Medication Management Effective Continuation Phase Treatment	29.82	25	3	
Metabolic Monitoring for Children and Adolescents on Antipsychotics- Total	40.26	50	4	
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics	65.19	75	5	
Follow Up After Emergency Department Visits for Mental Illness- 7 Day Total	42.20	90	6	
Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation Total	38.61	25	3	

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

Performance Improvement Projects (PIPs) were validated in accordance with the CMS-developed protocol titled, *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol validates project components and documentation to provide an assessment of the overall study design and project methodology. The components assessed include the following:

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

Select Health submitted two projects for validation – Diabetes Outcomes Measures and Well Care Visits for Foster Care Population. *Table 10: Performance Improvement Project Validation Scores* provides an overview of the previous year's validation scores with the current scores.

TABLE 10: Performance Improvement Project Validation Scores

Project	2019 Validation Score	2020 Validation Score
Diabetes Outcomes Measures	110/111=99% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results
Well Care Visits for Foster Care Population	PIP not active in 2019	83/83=100% High Confidence in Reported Results

The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year. The report noted COVID as a barrier to obtaining the records, which impacted the rates. The Well Child Visits PIP reported the baseline year as 2020 and other year's rates were included to gather trends for the HEDIS based measures.

Both PIPs scored in the "High Confidence in Reported Results" range. There is one recommendation for the Diabetes PIP displayed in *Table 11: Performance Improvement Project Recommendations*.

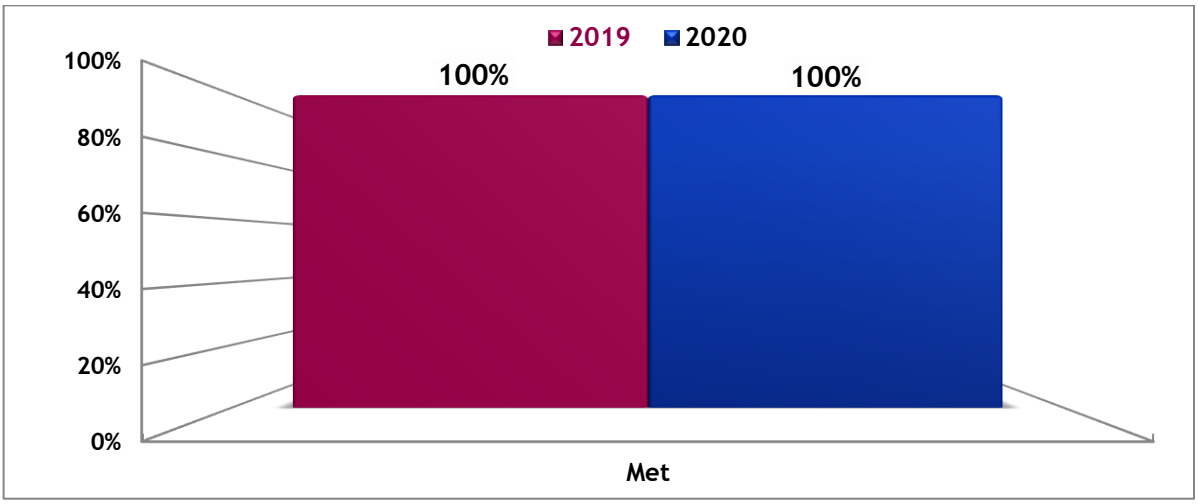
TABLE 11: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
Diabetes Outcomes	Was there any documented, quantitative improvement in processes or outcomes of care?	All rates showed a decline from the previous year.	Continue interventions to improve rates by addressing patient and provider barriers. Continue working on ways to mitigate the impact of COVID-19 on data collection and data retrieval.

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

For this review period, Select Heath met all the requirements in the Quality Improvement section as noted in *Figure 6: Quality Improvement Findings*.

Figure 6: Quality Improvement Findings



Strengths

- The performance measure validation found that Select Health was fully compliant.
- The HEDIS rate for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis – Total increased 19.78%.
- All the PIPs received validation scores in the "High Confidence Range."

Weaknesses

- Network provider participation in the Quality Assessment Performance Improvement Committee and the Quality of Clinical Care Committees is poor.

- The following HEDIS measure rates were determined to be areas of possible improvement for Select Health since these rates had a greater than 10% decline:
  - Asthma Medication Ratio for 51-64-year-olds
  - Initiation and Engagement of AOD Treatment for Alcohol Abuse or Dependence - Initiation
  - Initiation and Engagement of AOD Treatment for Alcohol Abuse or Dependence – Engagement
- The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year.

Recommendations:

- Continue recruiting efforts for network providers to serve on the Quality Assessment Performance Improvement Committee and the Quality of Clinical Care Committee.
- Engage the QI committees and Behavioral Health work group to address the decline in performance measures.
- Continue the interventions in the Diabetes Outcomes PIP to improve rates by addressing patient and provider barriers.
- Continue working on ways to mitigate the impact of COVID-19 on data collection and data retrieval.

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 includes utilization management documents, 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 policies guide staff in conducting UM services for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina. Additionally, they outline the structure, lines of responsibility, and standards used to make UM decisions.

Appropriate UM staff review service authorization requests using InterQual and other established criteria. Select Health assesses consistency in criteria application and decision-making through annual inter-rater reliability testing of both physician and non-

physician reviewers. Review of approval and denial files reflect consistent decision-making using approved criteria.

PerformRx is the pharmacy benefit manager (PBM) and is responsible for all pharmaceutical services. The plan uses the most current version of the Preferred Drug List (PDL) to fulfill pharmacy requirements. The PDL is accessible on the website.

The Care Management Program and Population Health Management (PHM) Strategy promote access to and delivery of physical and behavioral health services for identified members. During the onsite teleconference, Select Health presented highlights of the positive impact from the Enhanced Foster Care Management Program. Select Health uses care management techniques to ensure comprehensive, coordinated care for all members at various risk levels and follows a standard outreach process as it applies to continual care, transitional care, and discharge planning. However, requirements for Targeted Case Management (TCM) Services were not identified in a program description or policy.

Appeals

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

Select Health has established policies defining processes for handling appeals of adverse benefit determinations. CCME's review of appeal files revealed timely appeal acknowledgement, resolution, and notification of resolutions.

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. Minor issues were noted with appeals and CM documentation, and CCME offered recommendations to address them.

As noted in *Figure 7: Utilization Management Findings*, Select Health received "Met" scores for 98% of the standards and "Partially Met" scores for 2% of the standards.

Figure 7: Utilization Management Findings

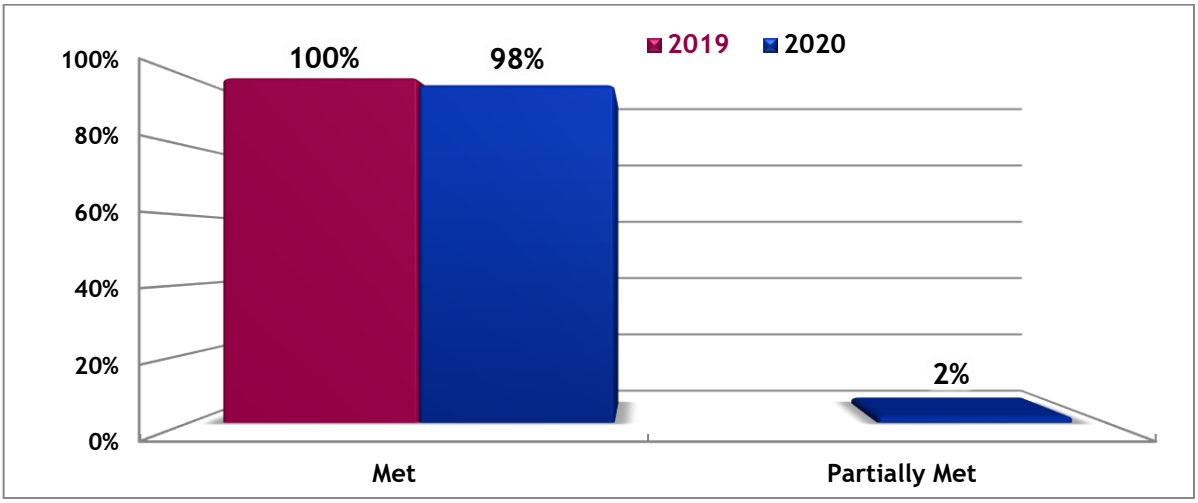


TABLE 12: Utilization Management Comparative Data

Section	Standard	2019 Review	2020 Review
Care Management and Coordination	The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2019 to 2020.

Strengths

- During the opening presentation, Select Health reported the Enhanced Care Management for Children and Families in Foster Care is having a positive impact.

Weaknesses

- Requirements for Targeted Case Management Services are not included in the program description or in policies.

Quality Improvement Plans

- Include the requirements for TCM services in a policy or other documents, as noted in *SCDHH Contract Section 4.2.27*.

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 11 current delegation agreements, as shown in *Table 13: Delegated Entities and Services*.

Table 13: Delegated Entities and Services

Delegated Entities	Delegated Services
NIA	Utilization Management Services, including preauthorization, post authorization and retrospective reviews. Provider Call Center Functions.
Citra	Nurse Call Line
BMH	Utilization Management Services, including preauthorization, post authorization and retrospective reviews. Provider Call Center Functions.
AU Medical, Prisma Health, Health Network Solutions, Medical University of South Carolina, PSG Delegated Services, Regional Health Plus, Roper St. Francis, St Francis Physician Services	Credentialing, Recredentialing

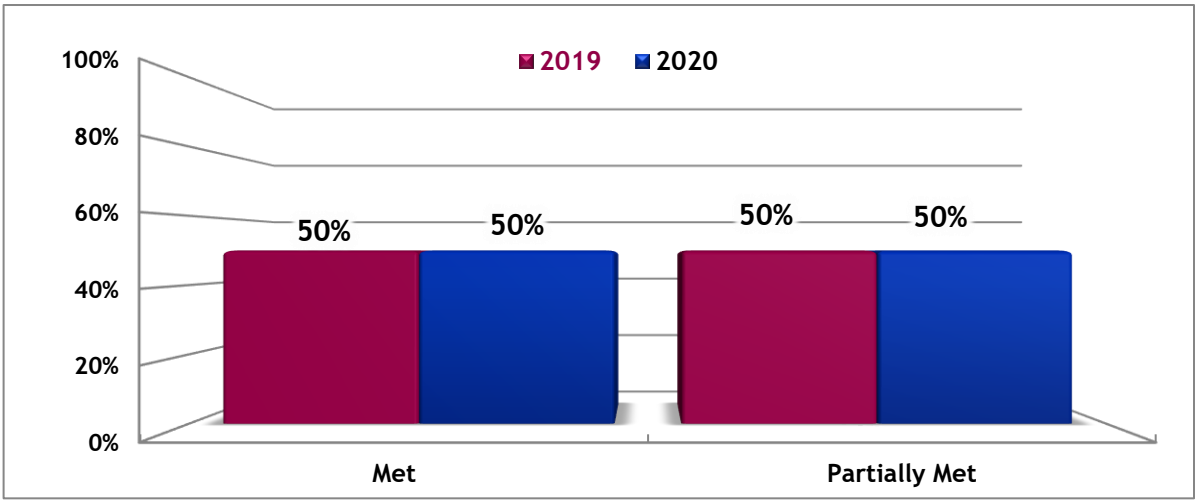
Per Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, and Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, prior to the initiation of the services being delegated, Select Health conducts a pre-delegation assessment to determine the potential delegates' ability to implement and perform the needed services. This policy also included the delegation agreement process.

Select Health provided the results of the annual monitoring of all delegates. For delegates not meeting the monitoring goals, corrective actions 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.

In the Delegation section, Select Health 50% of the standards received a "Met" score as noted in *Figure 8: Delegation Findings*.

Figure 8: Delegation Findings



Weaknesses

- The monitoring tools and the file reviews for the delegates providing the credentialing and recredentialing services did not include the verification of the CLIA certificates or the requirements for the nurse practitioners.

Quality Improvement Plan

- Ensure the delegation monitoring includes verifying the CLIA certificates and the requirements for nurse practitioners. Also, include CLIA and the requirements for nurse practitioners on the monitoring tools.

G. State Mandated Services

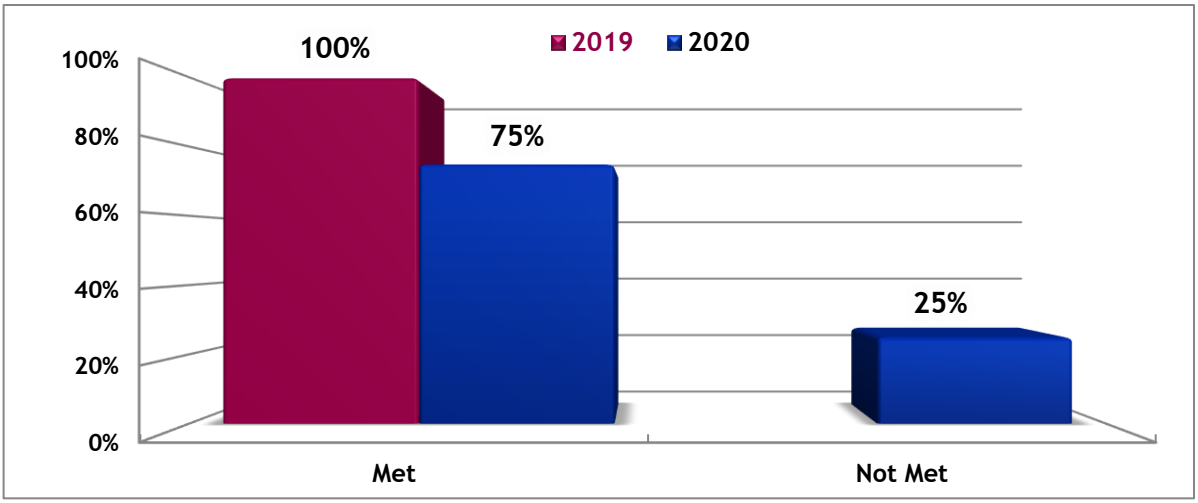
42 CFR Part 441, Subpart B

Select Health continuously monitors immunization and Early and Periodic Screening Diagnostic, and Treatment (EPSDT) compliance through frequent review of HEDIS metrics and provider performance on medical record reviews. The health plan has several processes and provider Engagement Activities in place to educate, notify, and remind providers of needed EPSDT services. Select Health provides all SCDHHS-required core benefits to members.

During the current EQR, CCME noted incorrect documentation of provider network geographic access standards in the Select Health of South Carolina Availability of Practitioners Report. This is a repeat finding from the previous EQR.

As noted in *Figure 9: State Mandated Services Findings*, Select Health received scores of "Met" for 75% of the standards and a score of "Partially Met" for 25% of the standards.

Figure 9: State Mandated Services Findings



Weaknesses

- A deficiency noted in the previous EQR related to documentation of provider network geographic access standards in annual reporting documents was noted again in the current EQR.

Quality Improvement Plans

- Ensure all deficiencies identified during the EQR process are addressed with actions to correct the deficiency and prevent recurrence.

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 11, 2020

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 2020 External Quality Review (EQR) of Select Health of South Carolina 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 11th and 12th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **September 25, 2020**. 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 2020

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.

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 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, and Pharmacy Programs.

10. The Quality Improvement work plans for 2019 and 2020.

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 those 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.

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 2019 through September 2020. 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 survey, 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 2019 through September 2020.

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 practice 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. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) for:
        i. Ten PCP's (Include two NP's acting as PCP's, 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 (including signed Ownership Disclosure Forms) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, 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) made in the months of October 2019 through September 2020. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of October 2019 through September 2020, 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: Appeals, Grievances, 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 2020

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Credentialing Committee minutes for 6/24/20.
3. Policy or standard operating procedure that addresses the process followed for reviewing and processing Quality of Care concerns. Please include the criteria used for determining cases that require review.
4. For credentialing and recredentialing, a list of databases, websites, etc. queried by WatchDog and Provider Trust.
5. Additional credentialing and recredentialing documentation noted on the attached “Items Needed for Credentialing and Recredentialing Files” list.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PM Validation Worksheet

Plan Name:	**Select Health**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2019**
Review Performed:	**2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2020 ***(Note: Due to COVID allowances, hybrid rates for HEDIS 2020 were the same as RY2019/HEDIS 2019)***

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 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 PIP Validation Worksheet

Plan Name:	**Select Health**
Name of PIP:	**WELL-CARE VISITS FOR FOSTER CARE MEMBERS**
Reporting Year:	2019
Review Performed:	11/2020

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 are 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 are 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**	Addresses 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 includes 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 utilized.
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 utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS sampling technical specifications were utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	HEDIS measures are 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 are 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 are based on HEDIS measures.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Administrative records and medical records are 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 are reported.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan is 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**	The report states that 2020 will be baseline year. For the measures, 2018 is displayed as the baseline year and CY2019 is reported as Year #0 COVID. Onsite discussion clarified information on measurement period labels.
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)**	**NA**	Baseline rates only.
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 are 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)**	**NA**	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)**	**NA**	Baseline rates only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline rates only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Baseline rates only.

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	NA	NA
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	NA	NA
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**83**
Project Possible Score	**83**
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:	**2019**
Review Performed:	**11/2020**

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 are 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 are included.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS Hybrid methodology was utilized.
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 utilized.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS Hybrid methodology was utilized.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are 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 measure 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 specifies data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was conducted according to 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 are 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 are documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation included both qualitative and quantitative discussion of results.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers 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)**	**NOT MET**	All rates showed a decline from the previous year. *Recommendation: Continue interventions to improve rates by addressing patient and provider barriers. Continue working on ways to mitigate the impact of COVID-19 on data collection and data retrieval.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	No improvement to assess.

Component / Standard (Total Points)	Score	Comments
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement to assess.
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	NA	NA
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**84**
Project Possible Score	**85**
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 Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2019
Review Performed	2020

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 2019 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-Adult 2019
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 2019
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 2019

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 has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019

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 2019
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 2019
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 2019
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 2019
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 2019

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 2019
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 2019

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 is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2019
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 2019

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 2019

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 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
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 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 1,530. The total completed surveys was 254 for a 17% response rate. This response rate is 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 2019 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Adult member population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
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 2019

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2019
Review Performed	2020

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 2019 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 2019
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 2019
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 2019

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 has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019

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 2019
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 2019
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 2019
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 2019
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 2019

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-Child CCC 2019
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-Child CCC 2019

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 is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2019
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 2019

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- Child CCC 2019

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 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
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 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 3463 with 777 completes for a 22% response rate for the total sample. The sample size was 1,638 with 364 completes for a 22% response rate for the general population. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Child with chronic conditions population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2019
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 2019

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2019
Review Performed	2020

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 2019 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 2019
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 2019
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 2019

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 has been tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019

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 2019
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 2019
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 2019
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 2019
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 2019

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-Child 2019
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-Child 2019

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 is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2019
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 2019

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- Child 2019

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 2019
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019
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 2019

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2019
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The sample size was 2,184. The total completed surveys was 473 for a 22% response rate. This response rate is lower than the NCQA target rate of 40 and may introduce bias into the generalizability of the findings. *Documentation: Documentation:* SPH Analytics Member Satisfaction Report- Child 2019 ***Recommendation:*** *Determine if there are any new barriers that occur for completion of surveys for the Child population. Continue to work with SPH Analytics to improve response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2019
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 2019

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	Select Health of South Carolina
Collection Date:	2020

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 & Procedure Program Management & Format Guidelines, describes procedures for developing new policies and procedures as well as reviewing and revising established policies and procedures. Policies and procedures are reviewed annually and revised as needed. Policies and procedures are housed on a shared internal drive for staff access. New employees review existing policies and procedures during orientation, and all staff are expected to read new and revised policies within a reasonable timeframe of implementation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Courtnay Thompson is Market President and Sean Popson is the Director, Plan Operations and Administration.
1.2 Chief Financial Officer (CFO);	X					Janice Fuller is the Director, Finance and serves as the Chief Financial Officer.
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					Philip Fairchild serves as the Claims Manager, and Vee-Ping Mast is the Encounters Manager.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					Claims processing and encounter data functions are conducted in Philadelphia, PA. Staffing appears to be adequate for these functions.
1.5 Utilization Management (Coordinator, Manager, Director);	X					Andrea Kilburn-Conyers is the Director of Market Clinical Population Health, Utilization and Care Management.
1.5.1 Pharmacy Director,	X					Kelly Martin is the Director, Pharmacy and Melissa Abad is Supervisor, Pharmacy.
1.5.2 Utilization Review Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Nathaniel Patterson is the Director, Quality Management.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Peggy Vickery is the Director, Provider Network Management. William Robinson and Jillian Dunnigan are Managers, Provider Network Management. Onsite discussion confirmed William Robinson services as the Provider Services Manager.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					James King is the Member Services Director and Toni Parnell is the Member Services Manager.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Kirt Caton is the Market Chief Medical Officer. Dr. Kathleen Domm is the Medical Director for Foster Care. Additional corporate Medical Directors include Dr. Cathryn Caton, Dr. Natasha Choyah, Dr. Melissa Pearce, and Dr. Courtney Jones.
1.10 *Compliance Officer;	X					The Organizational chart indicates Nicole Rosenblum is Interim Compliance Officer; however, onsite discussion confirmed Manuel Mendizabal is Compliance Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the Organizational Chart correctly reflects current staffing.
1.10.1 Program Integrity Coordinator;	X					Stacy Warner is the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Kelsey Austin is the Interagency Liaison.
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Michelle Cooke is a Psychologist licensed in South Carolina and serves as the Medical Director for behavioral health.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					On the Organizational Chart, CCME noted the line of reporting for the Manager, Rapid Response Outreach Team (RROT) is not indicated. *Recommendation: Revise the organizational chart to display the line of reporting for the Manager, RROT.*
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 Information Systems Capabilities Assessment (ISCA) documentation states the organization averages or exceeds

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						90% of clean claims paid in 30 days, and 99% of clean claims paid within 90 days. Those claims payment statistics meet the requirements stated in the *SCHHS Contract*. The documentation also notes that if a claim is not paid within 30 days, a supervisor reprioritizes the workload to ensure the claim is processed.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Select Health's systems are capable of accepting and generating Health Insurance Portability and Accountability Act (HIPAA) compliant transactions. Specifically, documentation notes that the organization typically receives 97% of its claims and encounter data electronically.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health's systems are capable of tracking enrollment and demographic data. The systems rely on unique member ID numbers to track members and the demographic data that has been collected. Additionally, enrollment updates are received using the State's HIPAA 834 files and are loaded into Select Health's systems within 24 hours of receipt. If there is a discrepancy, error, or data inconsistency, an error report is created within 24 hours. Finally, Select Health reconciles errors by updating the data to match that of the SCDHHS State System data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 systems can generate HEDIS reports. The organization uses National Committee for Quality Assurance (NCQA)-certified HEDIS software that queries a dedicated data repository for the creation of HEDIS reports. Analysts regularly review HEDIS reports to ensure they present the source data accurately.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Select Health's ISCA documentation includes detailed policies and procedures that address the organization's security mandates and the data security requirements of the *SCDHHS Contract*. Specifically, Select Health has policies and procedures for log management, vulnerability scanning, patch management, and remote access.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Select Health's ISCA documentation includes detailed policies and procedures that address the organization's security mandates. The policies and procedures emphasize the organization's position on assigning the minimum necessary physical and electronic access.
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 has a comprehensive disaster recovery (DR) plan that has recently been revised. The DR plan was tested in January 2020. The recovery test was conducted using a recovery site and resulted in the successful restoration of data systems and applications within organization's recovery time window.
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Select Health maintains a compliance plan to detect, prevent, and control fraud, waste, and abuse (FWA), and to ensure compliance with State and Federal regulations by following the guidance of the compliance plan. Select Health follows the AmeriHealth Caritas Code of Conduct and Ethics, which articulates the commitment to ethical behavior. The Code of Conduct and Ethics is written in a format that is easily understood, is reviewed annually, and is validated by the Chief Compliance Officer and the governing body.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Policy 168.102, Code of Conduct, Ethics, and Disciplinary Action, applies to all associates, contractors, subcontractors, vendors, and Boards of Directors. Select Health has established procedures and standards to maintain, monitor, and enforce quality services consistently on an organization-wide basis.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan and Program Integrity Plan describe the roles and responsibilities of the Compliance Officer and Program Integrity Coordinator.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						The 2020 SHC SIU Organizational Chart identifies the names and titles of Compliance personnel.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Information about the Compliance Committee;						The Compliance Plan, SHSC Compliance and Privacy Committee Charter, and Charter Listing provide the titles, voting status, roles, and responsibilities for the Compliance and Privacy Committee members. The committee meets quarterly, or a minimum of three times a year.
2.5 Compliance training and education;						Compliance and FWA training are conducted for new-hires and annually and are evaluated for effectiveness with quizzes at the completion of training modules. To achieve and ensure compliance with contractual obligations and applicable regulations, AmeriHealth Caritas and Select Health require the Board of Directors, associates, contingent workforce members, subcontractors/vendors, and first-tier, downstream, and related entities to receive training and education related to the Compliance Program. In addition, Select Health provides training and education to providers on correct billing practices.
2.6 Lines of communication;						The 2020 Compliance Plan outlines that Select Health follows the Office of the Inspector General guidance for implementation of "effective lines of communication" as follows: •Open line of communication between the compliance officer and company personnel •Written confidentiality and non-retaliation policies to encourage communication and reporting of incidents of potential fraud •Development of several independent

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reporting paths for employees to report fraud, waste, abuse so such reports cannot be diverted by supervisors or other personnel, and •Hotlines and other forms of information exchange to maintain open lines of communication.
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						Protocols are established by the Corporate Compliance Officer, in collaboration with the Select Health Compliance Officer and the Special Investigations Unit, to ensure investigations involving associates are performed in a timely and complete manner. The Compliance and Privacy Work Plan 2021 references providing oversight and monitoring as needed to ensure that the Corporate Audit Team performs focused audits to validate reliability and integrity of information, and the adequacy of internal controls.
2.9 Response to offenses and corrective action;						The Compliance Department conducts a timely, reasonable inquiry into any conduct where evidence suggests there has been misconduct related to payment or delivery of prescription drug items or services under the agreement between PerformRx and its client(s).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Potential instances of fraud, waste, and abuse may come to the attention of the Director of Compliance and Quality or other members of senior management through a number of sources (e.g., employee or beneficiary complaints, audits). The Compliance Department initiates a reasonable inquiry immediately, but no later than two weeks from the date the potential misconduct is identified.
2.10 Data mining, analysis, and reporting;						Policy 106.600.003 Internal Prospective Data Mining indicates that the Program Integrity Department is charged with preventing, detecting, investigating, and reporting fraud, waste, or abuse for the AmeriHealth Caritas Family of Companies. The department has cross-functional teams to support its comprehensive program to ensure the accuracy, completeness, and truthfulness of claims and payment data in accordance with all relevant state and federal laws and regulations. As part of the program, the Program Integrity Data Analytics Team prospectively data mines to identify and avoid provider overpayments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Exclusion status monitoring.						In accordance with Policy 106.200.001, Payment Integrity Retrospective Edit Approval, the Program Integrity Plan section entitled "Sanction and Exclusion Screening" stipulates that exclusions identified by the Plan and deemed valid for implementation must be supported by written justification. The Program Integrity Plan does not identify the process of monitoring the Social Security Death Master File. *Recommendation: Review and revise the Program Integrity Plan to address steps being taken to monitor the Social Security Administration's Death Master File*
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance and Privacy Committee assists the Director of Compliance with the implementation and oversight of the Compliance and Privacy Program. The Compliance and Privacy Committee serves in an oversight role to ensure the effectiveness of and to develop and set priorities.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy MED (PA) 150.402 outlines that SCDHHS identifies members who are using Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by SCDHHS. This program is known as the Beneficiary Lock-In Program. SCDHHS Program Integrity (PI) will restrict members to a two-year period in which they will obtain all Medicaid pharmacy services from one designated pharmacy.
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					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 member Protected Health Information pursuant to the Health Insurance Portability and Accountability Act, the Health Information Technology Economic and Clinical Health Act, and their implementing regulations; federal statutes and regulations governing the privacy of Substance Use Disorder patient records and all applicable state statutes, rules, and regulations.

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 related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Processes for credentialing and recredentialing providers for Select Health's network are documented in the Select Health of South Carolina Credentialing Program 2020 and in related policies.
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					Select Health's Credentialing Committee is a subcommittee of the Quality Assessment Performance Improvement Committee. The Credentialing Committee is composed of internal plan management, staff, and participating external providers representing a range of specialties, including family practice, internal medicine, pediatrics, obstetrics & gynecology, and behavioral health. The committee is chaired by the Market Chief Medical Officer and meets monthly. Credentialing Committee minutes reflected the presence of a quorum for each meeting and detailed discussion of provider files prior to making a credentialing/recredentialing determination.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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 delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: 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				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*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Death Master File and that the evidence clearly indicates the provider's Social Security Number was used for the query.
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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			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): following issues were noted: •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. •In six files, the PSV of the CLIA occurred more than 120 days prior to the recredentialing decision date. (Note: one was

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality, describes processes for sanctioning providers for provision of health care services that represent a serious deviation from, or repeated non-compliance with, recognized treatment patterns, standards of care, or Select Health's quality standards. Providers may appeal the proposed formal sanction to a Plan Hearing Panel. Potential quality of care concerns are investigated and, depending on the determination rendered by the Medical Director, may be referred to the Credentialing Committee for further review and recommendations for action. These actions may include panel restriction or termination

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						from the network. If the Credentialing Committee's decision or recommendation includes any reportable action, a report is made to the National Practitioner Data Bank (NPDB) and State regulatory agencies as appropriate by the Quality Management Department.
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					Policy CR.104.SC, Ongoing Monitoring – Licensure and Medicare/Medicaid Sanctions, states Select Health conducts a query at the time of initial credentialing and then monthly of the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), and SCDHHS termination, exclusion, and suspension lists. The Social Security Administration's Death Master File is queried at initial credentialing and recredentialing. Any potential matches are reported to the Compliance, Network Management, and Network Operations teams. The SCDHHS Division of Program Integrity is notified and action is taken, consistent with *42 CFR § 438.610*, which prohibits MCOs from having any affiliation with an entity or individual who is debarred, suspended, or otherwise excluded from participating in procurement activities.
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)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Policy NM 159.206, Availability of Practitioners, states Select Health's objective is to meet or exceed geographic access standards by ensuring that 95% of members have access to a PCP, OB/GYN and physician specialist within the identified mileage requirements. The policy defines geographic standards for: •family/general practice and pediatrics providers as 2 providers within 20 miles (urban/suburban) and 1 provider within 30 miles (rural) •internal medicine providers as 1 provider within 30 miles (urban/suburban and rural) The Select Health of South Carolina Availability of Practitioners Report states 100% of members have the defined access to these provider types. However, Table 1 on page 1 indicates the standard for urban/suburban internal medicine providers is 2 providers within 20 miles. This is inconsistent with Policy NM 159.206, which defines the standard as 1 provider within 30 miles (urban/suburban). This discrepancy was discussed during the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						onsite teleconference and Select Health staff responded that "during the development of the report there was a typing error while populating the standards however the results of the report are accurate and they meet the standards set forth in the policy. The report will be corrected." *Recommendation: Ensure geographic access reports are run using the contractually required standards for internal medicine providers listed in Policy NM 159.206 and in the Policy and Procedure Guide for Managed Care Organizations, Section 6.2. Also, ensure results documented in the Select Health of South Carolina Availability of Practitioners Report correspond to those standards.*
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy NM 159.206, Availability of Practitioners, states Select Health's objective is to meet or exceed geographic access standards by ensuring that 95% of members have access to a PCP, OB/GYN and physician specialist within the identified mileage requirements. The Policy defines geographic access requirements for specialists, including High Volume and High Impact Specialists as 1 within 30 miles (urban or suburban) and 1 within 50 miles (rural). However, The Select Health of South Carolina Availability of Practitioners report defines

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						urban/suburban access standards for cardiology, optometry, and otolaryngology as 1 within 50 miles. This discrepancy was discussed during the onsite teleconference and Select Health staff responded that "during the development of the report there was a typing error while populating the standards however the results of the report are accurate and they meet the standards set forth in the policy. The report will be corrected." *Recommendation: Ensure geographic access reports are run using the contractually required standards for specialty provider types listed in Policy NM 159.206, the SCDHHS Contract, Section 6.2.3.1.4, and in the Policy and Procedure Guide for Managed Care Organizations, Section 6.2. Also, ensure results documented in the Select Health of South Carolina Availability of Practitioners Report correspond to those standards.*
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, defines processes for assessing the provider network for geographic accessibility of providers. The policy states the geographic availability of network providers is monitored "On an annual and/or an "as needed" basis" to ensure members have appropriate access to health care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						services and to comply with required availability standards. Select Health confirmed they run geographic access reports at least annually to monitor the status of the network. Select Health also monitors the practitioner to member ratio for PCPs, OB/GYNs, and high volume/high impact specialists. PCPs include general/family practitioners, internal medicine, and pediatrics providers. High Volume providers include allergy/immunology, cardiology, optometry, otolaryngology, and OB/GYN. High Impact providers include cardiology, hematology/oncology, otolaryngology, orthopedic surgery, and OB/GYN. The Select Health of South Carolina Availability of Practitioners report (reporting period 2020) indicates geographic access goals were met for all categories.
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					Policy NM 159.101, Assessment of Special Needs Provisions and Cultural Responsiveness of the Provider Network, states Select Health requests race, ethnicity, and language data and information related to accommodating members with mental and physical disabilities from network providers on a voluntary basis when interacting via provider visits and during credentialing and recredentialing processes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The policy details procedures for collecting this information. Select Health contracts with Language Service Associates (LSA) for telephonic interpretation services in over 200 languages and at no cost for members and providers. LSA is available 24 hours a day, 7 days per week. The telephonic interpreting system can be accessed by members or providers by contacting Member Services during business hours or by contacting the Nurse Help Line. Members are informed of languages spoken by providers and office staff and of other language services offered through the practice in both the printed and online Provider Directory. Select Health's Cultural and Linguistically Appropriate Services Program (CLAS) promotes 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." Links to various cultural competency training websites are included on the website and some offer CME credits for physicians and physician assistants or contact hours for nurse practitioners.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Health Care Professional and Provider Manual (Provider Manual) includes an overview of Culturally and Linguistically Appropriate Services and states Network Management staff regularly remind providers about the importance of cultural competence and effective communication with Limited English Proficiency members as well as the responsibility to implement appropriate measures to ensure language, environmental, or other sensory barriers are removed. Of note, Select Health is a recipient of the Multicultural Health Care Distinction awarded by the National Committee for Quality Assurance.
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 outlined in the contract.	X					Policy NM 159.308, Assessment of Physician Directory Accuracy, specifies Provider Directory data elements that are required by NCQA for all PCPs, specialists, behavioral health providers, pharmacies, hospitals, certified nurse midwives, licensed midwives, long-term support services, and ancillary providers. Review of the Provider Directory supplied by Select Health, as well as the online directory confirmed all contractually required elements are included.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Network Management and Provider Network Operations departments are responsible for the accuracy of information in the online and paper Provider Directories. Updates are made to the online Provider Directory daily based on change forms submitted by Account Executives or directly from providers. Discussion during the onsite teleconference confirmed the printed version of the Provider Directory is updated monthly.
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, defines appointment access standards for PCPs and High Impact/High Volume providers. The standards listed in the policy are compliant with contractual 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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SCDHHS Contract, Section 6.2.3.1.5.3.
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, 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.*
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	X					The Provider Network Management staff conducts initial training within 30 calendar

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
providers.						days of placing a newly contracted provider or provider group on active status. Ongoing training is conducted as needed to ensure compliance with program standards. Policy NM 159.102, Provider Orientation and Ongoing Training, defines processes for initial and ongoing provider education. Ongoing training is provided via letters, newsletters, and other mailings, updates in the Provider Manual, in-person training sessions, etc. Select Health staff discussed changes that have been implemented for provider education in response to restrictions from COVID-19. These include frequent telephonic contact, conducting virtual training sessions, increased written communication (such as provider alerts and newsletters), and a dedicated section of the website for COVID-19.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with	X					Policy 391.100, Preventive and Clinical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
national standards and covered benefits and that are periodically reviewed and/or updated.						Practice Guidelines, describes the process for review and adoption of preventive health guidelines. The Clinical Policy Department reviews guidelines with board-certified practitioners, and guidelines are approved by the Clinical Policy Committee at least every two years and when there are changes.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					
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 of its members 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					Policy 391.100, Preventive and Clinical Practice Guidelines, describes the process for review and adoption of clinical practice guidelines The Clinical Policy Department reviews clinical practice guidelines with board-certified practitioners, and guidelines are approved by the Clinical Policy Committee at least every two years and when there are changes.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					The Quality Management Department monitors and trends continuity and coordination of care between PCPs and specialists, and other providers. Reports of monitoring are provided to appropriate quality committees and to individual practitioners. An annual summary report is provided to the Quality Assessment and Performance Improvement Committee

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						(QAPIC), and the QAPIC initiates action when continuity and coordination of care issues are identified. The annual assessment includes medical record review; analysis of member complaint, grievance, appeal, and PCP change requests; member and provider surveys; review of quality-of-care concerns; etc.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy QI 154.009, Medical Record Review, specifies documentation requirements and guidelines used for the evaluation of Medical Records. The Medical Record Review Evaluation Form is included as an attachment to the policy. The Provider Manual includes detailed information about medical record review standards and documentation requirements, and Select Health's website includes a "Guidelines for Evaluation of Medical Records" document.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The Medical Record Review policy (QI 154.009) states Select Health measures practitioner compliance with medical record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation requirements and standards. The Medical Record Review (MRR) process is conducted at least annually along with the Healthcare Effectiveness Data Information Set (HEDIS) survey. Reviewers use the Medical Record Review Evaluation Form when conducting the MRR. The Quality Management Department scores the evaluation forms and calculates results for each sampled PCP office and an overall aggregate score. All surveyed PCP offices are informed of their practice-specific scores, including any identified deficiencies for providers who fall below the expected benchmark. A follow-up review is scheduled for those who do not meet the benchmark, and a corrective action plan will be initiated for PCP groups that continue to not meet expectations. The QI Program Evaluation states the annual MRR was completed in May 2020, with an established benchmark of 90%. The overall 2020 Medical Record Review compliance rate was 99.5% (a 2.5 percentage point increase from the rate of 97% in 2019).
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 described in Policy MEM 129.100, Member Rights and Responsibilities. Instructions for accessing or obtaining a copy of member rights and responsibilities are published annually in member newsletters, posted on the website, and included in the New Member Packet.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in the Member Handbook, Provider Manual, member newsletters, and on the website.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
2.5 To be able to request and receive a copy of the member's medical records and request that they 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, 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.* *Recommendation: Correct policy MEM 129.124, Member Requested Print Material, page 3, to reflect members will not receive a paper copy of the Member Handbook upon enrollment.*
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						The Copayment Reference Guide is mailed 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;						Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual.
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;						Emergency care, post-stabilization care, and urgent care are defined in the Member Handbook. Members are informed that, in addition to their PCP, the Nurse Call Line is available 24 hours a day, seven days a week. The Member Handbook and website provide clear and specific information instructing members on the appropriate level of care for a routine, urgent, or emergent healthcare need for medical, dental, and behavioral health services.
1.7 Policies and procedures for accessing specialty care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The Member Handbook includes information on obtaining prescription medications and durable medical equipment. Members are directed to the website to view the Preferred Drug List and find participating pharmacies or to contact Member Services to obtain this information. Members may get a maximum 31-day supply of prescription medications with an available 72+ hour emergency supply while a prior authorization request is pending.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						Select Health notifies members in writing of significant changes to the program no later than 30 calendar days prior to implementation of the change, as described in Policy MS. MBRS.12, Member Notification of Plan Changes, and noted in the Member Handbook. Updates to the Preferred Drug List (PDL) and the Member Handbook are found on the member website and are appropriately dated to indicate the effective dates of change.
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Members can manage PCP selections and appointment scheduling through the member portal, the MyMobile App, or by calling Member Services for assistance.
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 Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						A description of the Provider Directory 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.
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 Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						The Member Handbook has sample pictures of the Healthy Connections and First choice ID Cards and describes the importance of members 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;						Adult members, 18 years and older, can obtain information for the three different types of Advance Directives from the Member Handbook, Member Services, or their provider. Specifically, members are instructed to call the Lieutenant Governor's Office on Aging for forms or additional information.
1.21 Information on how to report suspected fraud or abuse;						Fraud and Abuse are correctly defined in the Member Handbook and on the website. Instructions are provided for anonymously 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					The Spring 2020 Healthy Now Newsletter, the Member Handbook, and the Provider Directory inform members they can request a printed copy of the Member Handbook and the Provider Directory.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Select Health notifies members by mail of significant changes in benefits 30 days prior to the effective date of the change, as described in Policy MEM 129.105, Member Services Department, and in the Member Handbook. Policy MEM 129.125, Termination of a Specialist or Hospital, and Policy MEM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						129.117, Termination of Primary Care Provider, indicate Member Services sends a written notice of provider termination within 15 days after being notified of the termination.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy COM 220.105, The Production of Vital Documents in Alternative Formats, describes and outlines the processes Select Health uses to ensure member program materials are written in a clear, understandable manner and meet contractual requirements. Materials are made available in other languages when 5% or more of the resident population of a county is non-English speaking and speaks a specific language. Additionally, member materials include tag lines in large print, explaining the availability of written translation or oral interpretation services if needed. During the onsite teleconference Select Health Staff explained 18-point font is used for materials requiring large print and referenced Policy COM 220.105, The Production of Vital Documents, for documentation of this requirement.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					New members receive a health plan orientation phone call within 14 days of enrollment from a Customer Service Representative (CSR). During the call, the CSR discusses and confirms the member's choice for a primary care provider or assists the member in selecting one. In addition, new members receive the New Member Packet, which instructs them to contact Member Services to help select a PCP if needed.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy MEM 129.102, Disenrollment - Voluntary and Involuntary, defines the process for member-initiated disenrollment requests, and involuntary disenrollment initiated by Select Health or SCDHHS. Select Health must request member disenrollment in writing to SCDHHS.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members can access the website or Member Handbook for information on preventive health services, available case management programs, and instructions for obtaining educational support for medical, BH, 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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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					Select Health ensures EPSDT services for members through the month of their 21st birthday as stated in Policy QI 154.006, EPSDT/ Prevention and Screening Outreach. The policy describes processes and methods for notification, tracking, and follow-up of the EPSDT program and addresses barriers of low utilization by creating interventions to encourage members to use the services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					Select Health uses mailings relevant to the season, automated calls, text messaging, and the website to inform members about health risk factors and to encourage healthy behaviors. Discussions during the onsite teleconference revealed community health events were modified and less frequent due to COVID-19 precautions and restrictions.
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					The mobile app and the Member Handbook inform members about the Bright Start Maternal Child Care Management Program. Additionally, Select Health tracks timeliness of prenatal care through HEDIS monitoring of pregnant members.
III E. Member Satisfaction Survey						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.
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					SPH Analytics summarizes and details results from the Adult and Child Surveys. Select Health identified issues in adult and child Consumer Assessment of Healthcare Providers System (CAHPS) Surveys and created interventions to address them.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Member Satisfaction Survey results were discussed in a Quality Assessment Performance Improvement Committee meeting and noted in the minutes. Select Health contracts with SPH Analytics, a CAHPS Survey vendor to conduct the child and adult surveys. Although 2020 surveys were not validated, it is noted that the response rate declined for the child survey from 22% in 2019 to 15.3% in 2020, and the child with chronic conditions (CCC) survey response rate declined from 22% in 2019 to 15.% in 2020. However, the adult survey response rate improved from 17% in 2019 to 19.2% in 2020. Overall, response rates were below the National Committee for Quality Assurance (NCQA) target of 40%. *Recommendations: In addition to the other interventions that are in progress, continue working with SPH Analytics to increase response rates for Child, CCC, and adult surveys. The impact of COVID-19 may continue and oversampling or allowing for more follow-up may be necessary for 2021 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 informal and formal complaints and grievances. Additionally, grievance information is provided in the Member Handbook, in the Provider Manual, and on the website.
1.1 The definition of a grievance and who may file a grievance;	X					The term "grievance" is correctly defined in Policy MMS.100, Member Grievances and Appeals Process, the Member Handbook, and the Provider Manual. The documents appropriately indicate that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf.
1.2 Procedures for filing and handling a grievance;	X					Requirements for filing a grievance are documented in Policy MMS.100, Member Grievances and Appeals Process, in the Member Handbook, in the Provider Manual, and on Select Health's website. Select Health provides instructions, including mailing address and phone numbers, for grievances to be filed either orally or written and will acknowledge the grievance in writing within 1 calendar day. CCME could not identify the necessary information for members to include when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						filing a written grievance, such as name, address, ID number, or signed consent, if appropriate. *Recommendation: Include additional grievance instructions, in Policy MMS.100, Member Grievances and Appeals Process, the Member Handbook and on the website, that specifies all necessary information required when filing a written grievance.*
1.3 Timeliness guidelines for resolution of a grievance;	X					Policy MMS.100, Member Grievances and Appeals Process, the Member Handbook, and the Provider Manual indicate grievances are resolved within 90 calendar days of receipt. However, the Member Handbook does not include the full resolution requirement for when Select Health requests a grievance extension. The requirements for the plan to give prompt oral notice and inform the enrollee of the right to file a grievance are omitted. *Recommendation: Edit the Member Handbook to include the complete requirement for when the Select Health requests a grievance extension. Refer to the SCDHHS Contract, Sections 9.1.6.1.5.1* through *9.1.6.1.5.2.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Requirements for maintaining the grievance log and retention timeframes are appropriately documented in Policy MMS.100, Member Grievances and Appeals Process.
2. The MCO applies grievance policies and procedures as formulated.	X					Grievance files reflected timely acknowledgement, determination, and notification. Grievance resolution notices contained appropriate language, include all contractually required components, and directly addressed member's concerns. Member Service Advocates conducted appropriate email follow-ups with other departments when checking on the grievance status.
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. Minutes from the June 10, 2020 Quality of Service Committee meeting confirms presentation and discussion of the annual grievance summary and analysis. The minutes reflect grievances are tracked and trended to supply information on utilization management activities and includes performance metrics, barriers, and opportunities for improvement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Select Health's 2020 QI Program Description describes the program's structure, accountabilities, scope, goals, and available resources. The QI Program Description is reviewed and updated at least annually.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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's QI work plan identifies activities related to program priorities to address and improve the quality and safety of clinical care and services. The 2019 and 2020 work plans included the planned activity/deliverable, purpose/scope, target dates for completion, responsible party, and department. The annual work plan is developed by the Quality Management Department and forwarded to the Quality Assessment and Improvement Committee for review and approval.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Assessment Performance Improvement Committee (QAPIC) is the decision-making body ultimately responsible for the implementation, coordination, and oversight of the QI Program. The committee charter clearly outlines the responsibilities of the QAPIC. The Quality Clinical Care Committee is a subcommittee of the QAPIC. This committee is responsible for monitoring the clinical care services and outcomes.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QAPIC is chaired by the Market President. Other members of the committee include senior leaders, department directors, and other health plan staff. According to the committee charter, three to six network

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers are included as voting members of this committee. Only two providers were listed on the committee membership list. The Quality of Clinical Care Committee is chaired by the Chief Medical Officer. Voting members of the committee include four practicing primary care practitioners and specialists. However, the membership list and committee minutes only included three practitioners. Staff indicated there were issues getting network providers to participate in the committee meetings. Recruiting for new network providers is ongoing. *Recommendation: Continue recruiting efforts for network providers to serve on the Quality Assessment Performance Improvement Committee and the Quality of Clinical Care Committee.*
3. The QI Committee meets at regular quarterly intervals.	X					The meeting frequency for the Quality of Clinical Care Committee is noted as bi-monthly or, at a minimum, five times a year. For this EQR, the committee only met in November 2019 and January 2020. The March, May, and July 2020 meetings were canceled. Disbanding this committee was discussed with the QAPIC. Select Health indicated the decision was to continue with Quality of Clinical Care Committee and eliminate some

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of the repetitiveness between the QAPIC and the Quality of Clinical Care Committee.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions. The minutes provided with the desk materials indicated the required quorum was met for each meeting.
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					CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid. The performance measure validation found that Select Health was fully compliant with all HEDIS measures. There were several hybrid measures for which Select Health chose to report the measure year 2018 rate instead of the rate for measure year 2019, as allowed by NCQA. Of the rates reported, the HEDIS rate for Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) – Total increased 19.78%. The measures that showed a substantial decrease (>10% Decrease) in rate were Asthma Medication Ratio (amr) for 51-64 Year Olds (decreased by 12.6%) and the Initiation and Engagement of AOD Treatment for Alcohol

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Abuse or Dependence – Initiation decreased 12.57% and Engagement decreased 21.35%. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Recommendation: Engage the QI committees and Behavioral Health work group to address the decline in performance measures.*
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					Select Health submitted two projects for validation. They included Diabetes Outcomes Measures and Well Care Visits for Foster Care Population.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					The Diabetes Outcomes PIP showed a decline in the indicator rates from last year to this year. The report noted COVID as a barrier to obtaining the records, which impacted the rates. The Well Child Visits PIP reported the baseline year as 2020 and other years' rates were included to gather trends for the HEDIS based measures. Both PIPs scored in the "High Confidence in Reported Results" range. Details of the validation of the performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Recommendation: Continue the interventions in the Diabetes Outcomes PIP to improve rates*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						by addressing patient and provider barriers. Continue working on ways to mitigate the impact of COVID-19 on data collection and data retrieval.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Select Health's network providers can view reports that provide feedback on the practitioners' performance on key quality measures and indicate members having potential care gaps.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, Select Health evaluates the overall effectiveness of the QI Program and reports this evaluation to the QAPI Committee for review and recommendations. The Quality Improvement Program Evaluation 2019 addressed all aspects of the QI Program.
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					Select Health's Population Health Management (PHM) Strategy identifies and assists members with support to address their social, medical, and behavioral health needs. The Utilization Management (UM) Program Description outlines the goals, scope, and staff roles for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina. Policies, such as UM.008S, Clinical Criteria, are in place to guide staff on UM requirements and processes.
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					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Timeliness requirements are correctly documented in the UM Program Description, Policy UM.010S, Timeliness of UM Decisions, and the Member Handbook.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 consideration of new technology;	X					Policy UM.016S, Evaluation of New Technology, describes how requests for coverage of a new technology or a new application of an existing technology are assessed to determine appropriateness. Consideration is given to, but not limited to medical, BH, pharmaceutical, and medical devices.
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					Policy UM.318S, Preferred Provider Program, outlines the process and criteria for providers to be included in the program. Currently the program recognizes practitioners who perform bariatric surgery, spine surgery, and pain management procedures.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The 2020 Utilization Management Program description describes the roles of the UM Medical Director, the Corporate BH Medical Director, and the Corporate Population Health Medical Director. Responsibilities include, but are not limited to, identifying and implementing evidence-based practice guidelines, timely medical advice, participating in plan committees, and conducting Level II reviews.
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					The UM Program is reviewed, evaluated, and updated annually and presented to the Quality Assessment Performance Improvement Committee and the Clinical Care Committee. The 2019 UM Program Evaluation was approved on April 30, 2020.

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					Policy UM.008S, Clinical Criteria, and the UM Program Description list nationally recognized clinical support tools and evidence-based criteria used for determining medical necessity for physical health, behavioral health, durable medical equipment, and devices. Criteria such as, but not limited to, the *SCDHHS Contract*, InterQual Criteria™, and internal clinical policies are utilized. Individual circumstances and the local delivery system are considered when determining medical necessity.
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					Processes and requirements for covering hysterectomies, sterilizations, and abortions are described in Policy UM.312S, Hysterectomy and Family Planning, and in the Provider Manual. Additionally, the criteria for obtaining this service is available in the Member Handbook. The required forms for hysterectomies, sterilizations, and abortions are available in the Provider Manual and on the provider section of the website.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy UM.008S, Clinical Criteria, describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. Files reflect reviewers use appropriate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						criteria, demonstrate consideration of individual member's needs, and obtain additional information when needed to render a determination.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy UM.708S, Inter-rater Reliability, and the UM Program Description describe Select Health's process for assessing consistency in applying clinical criteria. A certified InterQual instructor conducts inter-rater reliability testing (IRR) quarterly for clinical reviewers and semi-annually for physician reviewers. A corrective action plan is established for reviewers scoring below the 90% benchmark. The 2019 UM Program Evaluation indicates the goal of 90% was met by all staff individually and as a group. Select Health staff confirmed the annual IRR testing scores for pharmacists and pharmacy technicians were 99% and 98%, respectively.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					PerformRx is the Pharmaceutical Benefit Manager for Select Health. Pharmacy benefit information is described in Policy MED (PA) 150.400, Pharmacy Benefits. The Pharmacy and Therapeutics (P&T) Committee consists of physicians, pharmacists, and other health professionals selected from within and outside of the plan. The committee meets at least three times a year and is primarily responsible for approving pharmacy policies and criteria.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Policy MED (PA) 150.402, Beneficiary Lock-In Program, indicates a 72-hour supply of medication will be approved while a prior authorization request is pending. The Provider Manual instructs providers

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to contact Select Health's Population Health department when specialty pharmacy services are required.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy UM.905S, Emergency Room Services, the Provider Manual, and the Member Handbook address emergency medical services and post-stabilization services and requirements. Select Health covers emergency and post-stabilization services without prior authorization for medical and behavioral health conditions.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization timeframes for UM approval files are consistent with the 2019 Integrated Utilization Management Program Description, Policy UM.008S, Clinical Criteria, Policy UM.010S, Timeliness of UM Decisions, and *SCDHHS Contract* requirements.
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					Denial files reflect attempts from the reviewer to obtain additional clinical information when needed to render a determination of medical necessity.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
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					Policy UM.017S, Notice of Adverse Determinations, outlines the process for handling adverse benefit determinations. CCME's review of denial files confirmed timeliness requirements for acknowledgment and notifying the provider were met. The Adverse Benefit Determination notices contained contractually required information.
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					Policy MMS.100, Member Grievances and Appeals Process, outlines the appeals processes. Information about appeals is included in the Provider Manual, Member Handbook, and on the member tab of the website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definition of the terms "adverse benefit determination" and "appeal," as well as information about who may file an appeal, are included in Policy MMS.100, Member Grievances and Appeals Process, the Provider Manual, the Member Handbook, and the website. These documents appropriately indicate that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing an appeal;	X					Requirements for filing an appeal are documented in Policy MMS.100, the Member Handbook, the Provider Manual, and on Select Health's website. Specific instructions for filing an appeal are included with the Adverse Benefit Determination notice.
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, the Member Handbook, and the Provider Manual indicate standard appeals are resolved within 30 calendar days of receipt and expedited appeals are resolved within 72 hours of receipt and meet all timeframe requirements for resolution and notification.
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy MMS.100, Member Grievances and Appeals Process, and appeal letter templates address contract requirements for appeal resolution notices.
1.7 Other requirements as specified in the contract.	X					Requirements for continuation of benefits are documented in Policy MMS.100, Member Grievances and Appeals Process, Policy SC_GAXX_051, Member Appeal Process, the Provider Manual, the Member Handbook, and letter templates.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO applies the appeal policies and procedures as formulated.	X					Appeal files reflect staff follow appropriate appeal processes. Determinations were issued by appropriate reviewers, and acknowledgments and resolutions were completed in a timely manner.
3. Appeals 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, explains a summary of all member appeals are reported to the Quality of Service Committee annually. Minutes from the Quality of Service Committee meeting on June 10, 2020 confirms presentation and discussion of the annual appeal summary and analysis. The minutes reflect appeals are tracked and trended to supply information on utilization management activities and include performance metrics, barriers, and opportunities for improvement.
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 case management/care coordination programs.	X					Policy PH-CC 201S, Care Management Standard of Practice, Population Health Management Strategy Document, and the 2020 Utilization Management Program Description describe Select Health's Case Management and Care Coordination Programs.
2. The MCO has processes to identify members who may benefit from case management.	X					The PHM Strategy Document, Policy PH-CC 201S, Care Management Standard of Practice, and Policy PH-CC 202 S, Referral to Care Management, describe methods for identifying and referring eligible members into case management. In addition to such avenues as claims data, laboratory and health risk assessment results, and internal and external

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						referrals, at-risk members are identified through population assessment and analysis.
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 set: Keeping Members Healthy (Low Risk); Managing Emerging Risk (Moderate Risk); Managing Multiple Chronic Illnesses and/or Disabilities (High Risk), 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 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.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Select Health confirmed Angela Williams is the Transition Coordinator.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The Population Health Management Strategy Program Description is submitted annually to the QAPIC. Minutes from the meeting on June 25, 2020 reflect discussion and approval of the program. The 2019 Population Health Strategy Impact Analysis provides a summary of key program metrics and analysis, barriers, and opportunities for improvement. SPH Analytics was selected by Select Health to conduct its 2019 Care Management Satisfaction Survey.
7. Care management and coordination activities are conducted as required.	X					CM files indicate care management activities are conducted as required and Care Managers follow policies to conduct the appropriate level of care management. HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed. Unable to contact letters and education materials are appropriately utilized.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					The 2019 UM Program Evaluation presented data on several utilization measures and noted efforts toward ED utilization reduction.

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					Per Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, and Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, prior to the initiation of the services being delegated, Select Health conducts a pre-delegation assessment to determine the potential delegates' ability to implement and perform the services being delegated. This policy also included the delegation agreement process. For this review, Select Health reported 11 current delegate

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						agreements.
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, 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. 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 delegated 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*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recredentialing activities include CLIA Certificates and the requirements for Nurse Practitioners.

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					Select Health ensures pediatric and adolescent immunization requirements are monitored as described in Policies QI 154.006, EPSDT/Prevention and Screening Outreach, and QI 154.009, Medical Record Review. Additionally, vaccine codes are conveniently listed in the Provider Manual. The 2019 Quality Improvement Program Evaluation details how child and adolescent immunizations are tracked, monitored, and evaluated for improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					Provider compliance with rendering EPSDT services is monitored via medical record reviews as noted in Policy QI 154.009, Medical Record Review. In addition to the Provider Manual, Policy QI 154.006,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						EPSDT/Prevention and Screening Outreach, and the Population Health Management Strategy document list several methods used to inform and remind providers of impending or missed EPSDT services.
2. Core benefits provided by the MCO include all those specified by the contract.	X					Select Health ensures all contractually required benefits are provided.
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			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.*