# South Carolina External Quality Review

## COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR '22-23

Submitted: April 21, 2023

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 (MCO) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all managed care organizations (MCOs) participating in the Healthy Connections Choices and/or Healthy Connections Prime Programs. The MCOs, also referred to as health plans, for the Healthy Connections Choices Programs include:

- Absolute Total Care (ATC)
- Healthy Blue
- Humana Healthy Horizons (Humana)
- Molina Healthcare of South Carolina (Molina)
- Select Health of South Carolina (Select Health)

For the Healthy Connections Prime Programs, the MCOs include:

- First Choice VIP Care Plus by Select Health of South Carolina (Select Health)
- Molina Healthcare of South Carolina (Molina)
- Wellcare Prime by Absolute Total Care (Wellcare)

CCME is also required to conducted EQR for SC Solutions, a primary care case management program providing care coordination for the Medically Complex Children's Waiver program.

The purpose of external quality reviews is to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. This is accomplished by conducting the following activities for each MCO: validation of performance improvement projects, performance measures, and surveys; review for compliance with state and federal regulations; and provider access studies. This report is a compilation of the findings of the annual reviews completed during the 2022 - 2023 EQR contract year.

In March 2023, CCME was notified by SCDHHS' Procurement Officer that the State was awarding the new EQR contract to CCME effective May 1, 2023. As a result of this notification, CCME began the process of transitioning from the 2022 – 2023 EQR Contract to the 2023 – 2024 EQR Contract. The reviews for Molina, Healthy Blue, and SC Solutions

are not included in this technical report as they will be completed after May 1, 2023. The results of those reviews will be reported in the 2023 – 2024 Annual Technical Report.

## Overall Findings

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

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality *(§ 438.224)*
- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess the MCO's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into seven areas.

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation
- State Mandated Services

The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, are included in the narrative of this report.

### *Administration*

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

The MCOs have established processes for ensuring routine review of policies and procedures and making revisions as necessary. Staff may access all policies on electronic platforms and are educated about new and revised policies.

During the 2023 EQR, it was apparent that Humana took action to address previously identified issues with policy management. Policies now undergo an annual review cycle, and it was clear that efforts were made to consolidate redundant policies and procedures. However, for the 2023 EQR, continued issues were noted related to policy management.

The Organizational Charts and supplemental documents for ATC and Select Health identified all key positions required by the *SCDHHS Contract* and clearly delineated departmental oversight to ensure that required health care products and services are provided to members. For Humana, it was unclear who fulfilled the requirements of the *SCDHHS Contract, Section 2* for the key positions of Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager. Also, one staff member was serving as both the Member Services Manager and the Contract Account Manager, which is out of compliance with contractual requirements. Humana's Organizational Chart did not display the operational relationships for several key areas, and operational relationships of staff were not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists.

Each MCO provided a comprehensive Compliance Plan and Code of Conduct. The plans ensure compliance training is provided at the time of employment and annually, thereafter. New-hire and annual compliance training and education are overseen by each MCO's Compliance Department. The Compliance Plans and related policies and procedures define the roles and responsibilities of Compliance Officers and Compliance Committees. Lines of communication as well as measures and initiatives for preventing, detecting, and correcting non-compliance with federal and state requirements are also included. Pharmacy Lock-in Programs have been established to manage members who use pharmacy services at a frequency or amount that is not medically necessary. Policies define procedures for identifying members for inclusion in the program, restricting the members to one pharmacy, notifying members of their inclusion in the program, and providing additional information and instructions.

Requirements and guidance for ensuring compliance with State and Federal laws and regulations for maintaining the confidentiality of Protected Health Information are found in the MCOs' Compliance Plans, Program Descriptions, Codes of Conduct, policies, procedures, etc.

The reviews of Information Systems Capabilities Assessment (ISCA) documentation confirmed the MCOs are capable of meeting contractual requirements. The plans regularly review and update policies and procedures for maintaining data and system security, and routinely test their Disaster Recovery Plans. ATC conducts internal audits to ensure requirements are being met, and regularly contracts with auditors to verify its system controls. Humana provides employees with cybersecurity training and sends frequent security threat reminders to staff. Select Health's disaster recovery capabilities allow data and system operations to failover to a second data center in the event of an outage.

### *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 MCOs have established committees that use a peer review process to make recommendations for credentialing decisions, meet at routine intervals and are chaired by Medical Directors or Chief Medical Officers. Regarding the committees, no issues were identified for Select Health. For ATC and Humana, identified issues were related to noncompliance with policy for membership requirements and unclear attendance documentation (ATC), and lack of a variety of specialists on the committee (Humana).

Program descriptions and policies provide information about credentialing and recredentialing processes and requirements. For organizational providers, ATC's policies did not define the credentialing application processing timeframe and circumstances under which an appeal is allowed. CCME reviewed samples of initial credentialing and recredentialing files for each MCO. No issues were noted for Humana and Select Health. For ATC, a minor issue was noted in one file related to failure to include a license verification that was stated as a requirement in ATC policy.

The health plans conduct various activities to assess the adequacy of their networks, including running routine Geo Access mapping and using various data analytics tools. The plans also consider grievance data and other factors, evaluate identified gaps, and take action to address the gaps. The MCOs contract with all required Status 1 provider types. Routine call studies as well as member satisfaction survey results and grievance data are used to evaluate provider compliance with appointment access standards. No issues were noted for ATC and Select Health. Humana's documentation incorrectly stated there is no contractual requirement for immediate/emergent care specialty visits. Processes are in place to ensure the provider networks can meet members' cultural, language, and other special needs, and the plans provide cultural competency education and resources to their providers.

As a part of the annual review process for all plans, CCME conducted a Telephonic Provider Access Study focusing on PCPs. All three plans received a score of "Met" for the standard requiring an improvement in the results of the Telephonic Provider Access Study. From the three MCOs reviewed, CCME identified a total population of 7,257 PCPs. From each plan's population, CCME randomly selected a total of 567 providers. The percentage of successfully answered calls ranged from 57% to 61%. Select Health had the largest improvement (4% increase) over last year's study, while Humana had a 2% increase, and ATC sustained the successful call rate from last year. The range of providers reporting that they accept the plan was 77% to 90%. Providers accepting new patients ranged from 61% to 67%. When compared to last year, this is a decline for all three plans.

Each plan conducts initial and ongoing provider education as specified in policies, training plans, etc. Humana's Provider Orientation and Annual Training Policy (SC.NNO.007) was not specific to SC and referenced an orientation checklist that is not used. This was a repeat finding from the previous EQR. Initial orientation is conducted via face to face sessions, welcome calls, and/or mailed resources. Ongoing provider education is accomplished via provider meetings, regional provider training sessions, Provider Manual updates, newsletters, websites, provider portals, etc. Provider Manuals include detailed information for providers to understand health plan operations and requirements; however, Humana's Provider Manual did not include information about reassignment of a member to a different PCP.

Processes are in place for reviewing and adopting preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) that are relevant to the member populations and originate from recognized sources. The health plans educate providers about the guidelines through general provider education sessions, plan websites, newsletters, etc.

The health plans educate their network providers about medical record documentation and maintenance requirements and assess provider compliance through routine medical record audits. Audit results are used for quality improvement activities.

Health plan policies define processes for monitoring and evaluating continuity and coordination of care. This is accomplished through activities such as medical record audits and monitoring HEDIS measures, member and provider satisfaction surveys, and other internal data (UM, pharmacy, appeal, grievance, etc.). Results of the monitoring are used for quality improvement activities.

### *Member Services*

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

New members are informed of their rights and responsibilities in the new member welcome packets, Member Handbooks, and on each health plan's website. Policies and

onsite discussion confirmed that new member materials are provided within 14 calendar days after receipt of enrollment information.

The Member Handbooks and new member welcome packets serve as educational resources for members to understand each health plan's operations, processes, services, covered benefits, and contact information. Members receive notice of any significant changes in benefits and the provider network at least 30 calendar days before the intended effective date of the change. The steps for requesting assistance with interpretation services or materials in languages other than English are clearly outlined in printed materials and manuals. Members also have access to a nurse advice line 24 hours a day, seven days a week.

Policies for each MCO detail processes for member enrollment and disenrollment. Humana requires members to file a grievance prior to requesting disenrollment. The *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5,* includes no requirement that members must file a grievance with the health plan to request disenrollment.

Member satisfaction survey validation for each health plan was performed based on the CMS Survey Validation Protocol. A certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor conducted a formal annual assessment of member satisfaction that met all the requirements of the CMS Survey Validation Protocol. The minimum number of completed surveys was less than the NCQA target of 411 surveys for the three populations surveyed for each health plan.

Processes and requirements for handling grievances and requirements were found in the health plan's policies, Member Handbooks, Provider Manuals, and on plan websites. Definitions and timeliness requirements for grievance resolution were detailed in the policies. For Humana, it was noted that the definition of a grievance was incorrect in their policy, in the Member Handbook and on the website.

CCME reviewed a sample of grievance files for each health plan. Overall, the files demonstrated that grievances were processed timely and appropriate notifications of resolution were provided.

### *Quality Improvement*

*42CFR §438.330, 42 CFR §457.1240 (b)*

The MCOs are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQRs of the SC health plans included review of the programs' structures, work plans, and program evaluations, as well as validations of performance measures and performance improvement projects.

Each MCO provided their current QI Program Descriptions. These program descriptions provided an overview of the QI Programs that have been established to improve the quality of care delivered to their members. The QI Program Descriptions for ATC and Select Health included each program's structure, goals, scope, and methodology. Humana's program description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships).

Annually, each MCO develops a work plan to help manage workflow, assign tasks, and track various components of the QI Program. The work plans included the scope, activity description and objectives, responsible party, timeline, and status for each activity.

Each health plan has established a committee responsible for the oversight of their QI Programs. These committees evaluated the results of the QI activities and made recommendations as needed. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QI Committee. However, Humana's committee minutes for meetings held in 2022 did not include any participating network practitioners. The minutes for the meeting held in January 2023 documented one network practitioner and one physician consultant, not participating in Humana's network, had been added.

Each MCO evaluates the overall effectiveness of the QI Program and reports the evaluation to the Board of Directors and to various Quality Improvement Committees. Each plan provided copies of the Annual Evaluations for review. Humana's 2021 – 2022 QI Program Evaluation lacked the results and analysis for several activities. Also, the goal for measuring the credentialing and recredentialing activities were incorrect. These deficiencies were discussed during the onsite. Staff explained the QI Program Evaluation was created for accreditation purposes and did not contain 12 months of data.

### *Performance Measure Validation*

MCOs are required to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the performance measures (PMs) reported, CCME uses the CMS Protocol, Validation of Performance Measures. All plans use HEDIS® certified vendors or software to collect and calculate the measures, and all were found to be "Fully Compliant." Health plan rates for the most recent review year are reported in the Quality Improvement section of this report. *Table 1: HEDIS Measures with Substantial Increases or Decreases* highlights the HEDIS measures with substantial increases or decreases in rate from last year (MY2021) to the current year (MY2022). The rates highlighted in green show a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease of more than 10 percent. Since this was the first year Humana reported HEDIS measures, no comparisons were made for Humana.

**Table 1: HEDIS Measures with Substantial Increases or Decreases**

| Measure/Data Element | ATC | Select Health |
|---|---|---|
| **Effectiveness of Care: Respiratory Conditions** | | |
| Pharmacotherapy Management of COPD Exacerbation (pce) | | |
| *Systemic Corticosteroid* | 68.83% | 62.64% |
| **Effectiveness of Care: Cardiovascular Conditions** | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | 79.07% | 68.12% |
| **Effectiveness of Care: Behavioral Health** | | |
| Pharmacotherapy for Opioid Use Disorder (pod) | | |
| *Total* | 41.03% | 35.11% |

ATC demonstrated a substantial increase in the Persistence of Beta-Blocker Treatment After a Heart Attack measure. There were no measures that demonstrated a substantial increase for Select Health.

Three measures showed a decline in the rates for Select Health. Those included Pharmacotherapy Management of COPD Exacerbation, Systemic Corticosteroid; Persistence of Beta-Blocker Treatment After a Heart Attack; and Pharmacotherapy for Opioid Use Disorder, Total. For ATC, there were no measures that demonstrated a substantial decrease.

### *Performance Improvement Project Validation*

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

Each health plan is required to submit PIPs to CCME for review annually. CCME validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Six projects were validated for the three health plans. Results of the validation and project status for each project are displayed in *Table 2: Results of the Validation of PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

**Table 2: Results of the Validation of PIPs**

| Project | Validation Score | Project Status |
|---|---|---|
| **ATC** | | |
| Adult Access to Preventive Health Care (AAP) | 80/80=100% High Confidence in Reported Results | The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The baseline rate was CY2020 with a rate of 77.28%. The rate improved at remeasurement 1 (CY2021) to 78.18%. The goal is 81.97%. |
| Hospital Readmissions | 80/80=100% High Confidence in Reported Results | The Readmissions PIP aims to reduce the annual rate of readmissions within 30 days for 18–64-year old patients. The baseline rate was 18%, which was reduced to 16.2%, and further reduced to 15.5% for remeasurement 2 (ending June 2022). The goal was to reduce the rate to 15.5% and was therefore met. |
| **Humana** | | |
| Human Papillomavirus Vaccine (HPV) | 79/79=100% High Confidence in Reported Results | According to the 2018 South Carolina Health Assessment, SC ranks in the lowest quartile nationally for adolescents having received one or more doses of the HPV vaccine. As of April 2022, 22% of Humana's Healthy Horizons population is between the ages of 7 and 13. Well child visit compliance rates tend to decrease for this age group. Although vaccine rates continue to rise in SC, unfortunately, the rates for HPV immunizations have not increased at the rate of other vaccines in SC or the US. The importance of this PIP is to increase the complete uptake of HPV vaccines by educating adolescents, parents, and providers on the importance of preventing cancer and common misconceptions of the HPV vaccine. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the HPV vaccines to 38.44%. The PIP report showed a rate of 1.82% in Q3, which was the MY 2021 final rate, and 3.85% in Q4, which is the interim MY 2022 rate. This was an improvement toward the goal rate of 36.5% (goal change for NCQA from 38.44% to 36.5%). |
| Prenatal and Postpartum Compliance | 73/74=99% High Confidence in Reported Results | The objective of the project is to increase the rate of eligible women receiving timely prenatal and postpartum care. Timely prenatal care is defined as care received within 42 days of enrollment or during the first trimester. Timely postpartum care is defined as care received between 7 and 84 days post-delivery. The prenatal goal is to increase the compliance rate of 84.49% to 85.4% and to increase the postpartum goal from 57.59% to 77.37%. Although all members will be outreached, the target population measured will be all members who delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Members who did not have a live-birth and those using Hospice services anytime during the measurement year will be excluded. |

| Project | Validation Score | Project Status |
|---|---|---|
| | | For the timeliness of prenatal care measure, the final MY2021 rate reported in Q3 was 100% (although the sample included only 3 women); the interim MY2022 rate was 84.49% (target rate 85.4%). This rate declined, although the denominator for the baseline was very small so the reliability of that rate is difficult to ascertain. For postpartum care measure, the baseline rate was 0%, which increased to 57.59% (interim MY 2022) with a goal of 77.37%. |
| **Select Health** | | |
| Comprehensive Diabetes Care Outcomes Measures | 91/91=100% High Confidence in Reported Results | The aim for the diabetes PIP is to lower HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8).<br>The Diabetes outcomes PIP showed improvement in the HBA1C <8% measures from 36.98% to 42.82%. Blood Pressure Control (<140/90) improved in the latest remeasurement from 53.04% to 63.02%. |
| Well-Care Visits for Children and Adolescents in Foster Care in South Carolina | 91/91=100% High Confidence in Reported Results | The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase compliance with Well-Care visits for children and adolescents in foster care. During the pilot project, Select Health found there was no defined process point for sharing health, behavioral health, and dental history or detail prior to placement, and no process for sharing information between Select Health and SC Department of Social Services (SCDSS) while the child is in placement. Another significant finding of the Health Care Pilot and Case Process Review was that, despite the fact that virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) Well-Child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits.<br>The Adolescent Well-Care rate declined from 71.11% to 69.59%. The Well-Child in the first 15 months (6+ visits) rate improved from 54.78% to 58.16%. The Well-Child visits in 3rd, 4th, 5th, and 6th years of life rate increased from 81.45% to 83.38%. The W30 measure (Well-Child visits in the first 30 months of life (0 – 15 months) improved from 54.78% to 58.16%. The W30 for 15-30 months improved from 85.53% to 89.33%. The WCV for 3-11 years improved from 76.36% to 77.42%; for 12- 17 years it improved from 75.71% to 76.02%; for 18-21 it declined 46.41% to 38.46%. The total WCV rate declined 73.87% to 73.51% in 2021. |

### *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)*

ATC, Humana, and Select Health have appropriate program descriptions, policies, and guidelines that describe how utilization management (UM) services are operationalized for physical health, behavioral health, and pharmaceutical services for members. The purpose, goals, objectives, and staff roles for physical health, behavioral health, and pharmaceutical services are described appropriately in their program descriptions and polices.

Each health plan's Chief Medical Officer/Medical Director provides oversight of the UM Program. The responsibilities for this position are to provide oversight of the UM Program, conduct Level II Reviews, participate in peer-to-peer consultations, etc. UM staff responsible for conducting Level I medical necessity reviews include clinical associates that are nurses or behavioral health professionals.

Various policies and guidelines provide guidance to staff in making clinical determinations. Each health plan uses evidence-based guidelines such as InterQual, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM), etc. for conducting initial review.

CCME reviewed a sample of approval and denial files for each health plan. Overall review of the approval files reflected use of appropriate criteria when making clinical determinations. Additionally, the clinical determinations were completed within the required contractual guidelines for standard and expedited requests. In review of the denial files, the denial decisions were communicated in a timely manner to members and providers. However, there were some identified issues with each health plan.

ATC, Humana, and Select Health are responsible for processing and managing appeals. Various policies, the UM Program Description, Provider Manual, and Member Handbook outline each health plan's appeals process.

CCME conducted a review of appeal files, and findings reflected various strengths and weaknesses. ATC's appeal files reflected that appeal guidelines and processes were followed according to contractual standards. Humana's and Select Health's file review demonstrated the health plans did not consistently process standard and expedited appeals according to guidelines in their policies and in federal regulations.

ATC, Humana, and Select Health's Case Management (CM) Program Descriptions, UM Program Descriptions, Provider Manuals, Member Handbooks, and various policies provide a descriptive overview of the approach to providing CM services to members. Members may self-refer for CM services, and referrals can be received from various sources such as providers, vendors, delegated entities, etc. For ATC and Select Health, predictive modeling is also used to aid in identifying potential members for CM services. However, Humana indicated that the health plan does not currently have predictive modeling

software to identify members for care management but plans to implement a predictive modeling tool by the end of the year. In the interim, Humana reported that hospital data, claims, direct referrals, etc. are utilized to identify members for potential care management.

CCME conducted a CM file review and found that, overall, CM activities are performed as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources. However, there was an issue with care coordination for Humana's files.

ATC, Humana, and Select Health have outlined policies and guidelines in analyzing trends and patterns for over and underutilization.

### *Delegation*

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

CCME's review of delegation functions included delegate lists provided by the MCOs, sample delegation contracts, delegation monitoring materials, and documentation of delegation oversight. ATC reported delegation agreements with 25 entities, while Humana reported delegation agreements with 20 entities and Select Health reported 13 delegation agreements.

Each of the health plans has policies that define delegation requirements, processes for evaluating potential delegates, approval of delegation, implementing written delegation agreements, and conducting ongoing monitoring and annual evaluations for existing delegates. Pre-delegation assessments are conducted to evaluate potential delegates' abilities to conduct delegated activities in compliance with health plan standards and requirements of the *SCDHHS Contract*, NCQA, etc. When delegation is approved, written delegation agreements that specify the delegated activities, responsibilities, performance expectations, reporting requirements, and consequences for substandard performance are executed.

Review of oversight documentation revealed that annual oversight included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions. However, ATC did not provide evidence of the required annual evaluation for one delegate.

### *State Mandated Services*

*42 CFR § Part 441, Subpart B*

The reviews confirmed that each of the health plans provide all core benefits required by the *SCDHHS Contract*.

Providers are educated about EPSDT requirements and recommended immunizations and other preventive care recommendations in a variety of ways. The MCOs inform providers of members with gaps in care and evaluate provider compliance with the provision of

recommended immunizations and EPSDT services. Activities conducted to evaluate this compliance include medical record compliance audits and monitoring HEDIS measures, population health dashboards, and UM reporting.

## Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, CCME requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected. During the current EQR, CCME assessed the degree to which each health plan implemented the actions to address deficiencies identified during the previous EQR. Findings of the EQRs confirmed ATC and Select Health corrected all issues identified during the previous EQR. Humana was found to have uncorrected deficiencies from the previous EQR related to:

- References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana confirmed in both 2022 and 2023 that this checklist is not used.
- Lack of a variety of participating network providers as members of the committee responsible for the Quality Improvement activities.
- Appeal resolution letters that did not indicate the decision to uphold the original denial was made by a physician with clinical expertise in treating the member's condition and use of verbiage in the letters that appeared to be above the 6th grade reading level.

## Conclusions

For the 2022-2023 EQRs overall, the health plans met all the requirements for Coordination and Continuity of Care *(§ 438.208, § 457.1230),* Confidentiality *(§ 438.224)*, Practice Guidelines *(§ 438.236, § 457.1233)*, and Health Information Systems *(§ 438.242, § 457.1233)*.

*Table 3: Compliance Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of compliance scores specific to each of the 11 Subpart D and QAPI standards.

**Table 3: Compliance Results for Part 438 Subpart D and QAPI Standards**

| Category | Report Section | Total Number of Standards | ATC | | Select Health | | Humana | |
|---|---|---|---|---|---|---|---|---|
| | | | Number of Standards Scored as "Met" | Overall Score | Number of Standards Scored as "Met" | Overall Score | Number of Standards Scored as "Met" | Overall Score |
| Availability of Services *(§ 438.206, § 457.1230)* and Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)* | Provider Services, Section II. B. Adequacy of the Provider Network | 8 | 8 | 100% | 6 | 75% | 7 | 87.5% |
| Coordination and Continuity of Care *(§ 438.208, § 457.1230)* | Utilization Management, Section V. D. – Care Management | 9 | 9 | 100% | 9 | 100% | 9 | 100% |
| Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* | Utilization Management, Section V. B. – Medical Necessity Determinations | 14 | 14 | 100% | 14 | 100% | 13 | 92.8% |
| Provider Selection *(§ 438.214, § 457.1233)* | Provider Services, Section II. A. – Credentialing and Recredentialing | 39 | 38 | 97% | 39 | 100% | 39 | 100% |
| Confidentiality *(§ 438.224)* | Administration, Section I. E. - Confidentiality | 1 | 1 | 100% | 1 | 100% | 1 | 100% |

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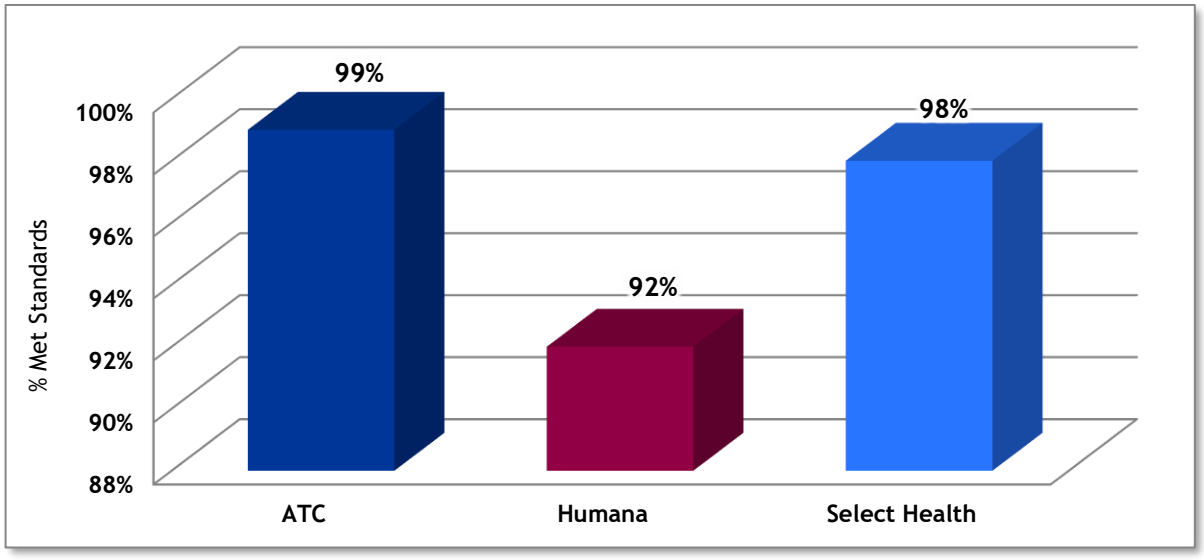
| Category | Report Section | Total Number of Standards | ATC | | Select Health | | Humana | |
|---|---|---|---|---|---|---|---|---|
| | | | Number of Standards Scored as "Met" | Overall Score | Number of Standards Scored as "Met" | Overall Score | Number of Standards Scored as "Met" | Overall Score |
| Grievance and Appeal Systems *(§ 438.228, § 457.1260)* | Member Services, Section III. G. - Grievances<br><br>Utilization Management, Section V. C. - Appeals | 20 | 20 | 100% | 18 | 90% | 18 | 90% |
| Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)* | Delegation Section | 2 | 1 | 50% | 2 | 100% | 2 | 100% |
| Practice Guidelines *(§ 438.236, § 457.1233)* | Provider Services, Section II. D. - Primary and Secondary Preventive Health Guidelines<br><br>Provider Services, Section II. E. - Clinical Practice Guidelines for Disease and Chronic Illness Management | 11 | 11 | 100% | 11 | 100% | 11 | 100% |
| Health Information Systems *(§ 438.242, § 457.1233)* | Administration, Section I. C. - Management Information Systems | 7 | 7 | 100% | 7 | 100% | 7 | 100% |
| Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240 )* | Quality Improvement Section | 14 | 14 | 100% | 14 | 100% | 11 | 79% |

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

The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2022 – 2023 EQRs.

**Figure 1: Percentage of Met Standards**




*Scores were rounded to the nearest whole number*

The following table provides an overview of the scoring for each section of the EQR.

**Table 4: Overall Scoring**

| | Met | Partially Met | Not Met | Not Evaluated | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|
| Administration | | | | | | |
| ATC | 40 | 0 | 0 | 0 | 40 | 100% |
| Humana | 35 | 2 | 3 | 0 | 40 | 88% |
| Select Health | 40 | 0 | 0 | 0 | 40 | 100% |
| Provider Services | | | | | | |
| ATC | 75 | 1 | 0 | 0 | 76 | 99% |
| Humana | 73 | 2 | 1 | 0 | 76 | 96% |
| Select Health | 74 | 2 | 0 | 0 | 76 | 97% |
| Member Services | | | | | | |
| ATC | 33 | 0 | 0 | 0 | 33 | 100% |
| Humana | 31 | 1 | 1 | 0 | 33 | 94% |
| Select Health | 33 | 0 | 0 | 0 | 33 | 100% |
| Quality Improvement | | | | | | |
| ATC | 14 | 0 | 0 | 0 | 14 | 100% |

| | Met | Partially Met | Not Met | Not Evaluated | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|
| Humana | 11 | 2 | 1 | 0 | 14 | 79% |
| Select Health | 14 | 0 | 0 | 0 | 14 | 100% |
| Utilization/Care Coordination | | | | | | |
| ATC | 46 | 0 | 0 | 0 | 46 | 100% |
| Humana | 42 | 3 | 1 | 0 | 46 | 91% |
| Select Health | 43 | 2 | 0 | 0 | 45 | 96% |
| Delegation | | | | | | |
| ATC | 1 | 1 | 0 | 0 | 2 | 50% |
| Humana | 2 | 0 | 0 | 0 | 0 | 100% |
| Select Health | 2 | 0 | 0 | 0 | 2 | 100% |
| State Mandated Services | | | | | | |
| ATC | 4 | 0 | 0 | 0 | 4 | 100% |
| Humana | 3 | 0 | 1 | 0 | 4 | 75% |
| Select Health | 4 | 0 | 0 | 0 | 0 | 100% |
| Totals | | | | | | |
| ATC | 213 | 2 | 0 | 0 | 215 | 99.07% |
| Humana | 197 | 10 | 8 | 0 | 215 | 92% |
| Select Health | 210 | 4 | 0 | 0 | 214 | 98.13% |

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

## *Coordinated and Integrated Care Organizations Annual Review*

CCME conducted an EQR of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those organizations include First Choice VIP Care Plus by Select Health of SC (Select Health), Molina Healthcare of SC (Molina), and Wellcare Prime by Absolute Total Care (Wellcare). For this contract year, CCME completed an External Quality Review of Select Health and Wellcare. The EQR for Molina was postponed and will be completed in May 2023 and reported in the 2023 – 2024 Annual Technical Report.

The process used by CCME for the EQR activities is based on the *CMS Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations*. To conduct the review, CCME requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over- and under-utilization data, and care transition files.

### *Provider Network Adequacy*

The CICOs are required by contract to maintain a network of Home and Community Based Service (HCBS) providers that is sufficient to provide all enrollees with access to a full range of covered services in each geographic area. The CICOs are also required to have a network of Behavioral Health (BH) providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard. CCME requested a complete list of all contracted HCBS providers currently in Select Health's and Wellcare's networks.

The minimum number of required providers for each county was calculated and compared to the number of current providers for seven different services. For Select Health, 42 counties were documented as having members, with one member in a county labeled as "Other." Of the 294 services across 42 counties, 294 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%.

Select Health submitted information on their BH providers. The requirements as set forth by the State were compared to the submitted information. The Geo Access reports showed that at least 99% of members have access to at least one BH outpatient and inpatient provider and at least one CMHC using the 50-miles radius requirement for Metro areas, and 100% of members have access for Micro and Rural areas. Select Health met all network adequacy requirements for BH providers.

Wellcare documented having members in 46 counties. The HCBS adequacy rate for this year was calculated as 99.7% (321 service minimums out of 322 services were met). Aiken county only had one unique, contracted Adult Day Health provider. The minimum number required for Aiken County is two. CCME recommends that Wellcare recruit additional Adult Day Health providers who can serve members in Aiken County.

Wellcare's Quest Analytics' Geo Access Network Analysis report showed that 99.9% of members had access to a psychiatrist; 99.4% had access to a psychologist; 100% had access to a social worker; and 99.9% had access to a CMHC. Wellcare met all network adequacy requirements for BH providers.

### *Evaluation of Over/Under Utilization*

The CICOs are required to monitor and analyze utilization data for trends or issues that may provide opportunities for quality improvement. The over- and under-utilization monitoring focuses on five key indicators:  30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services. Select Health and Wellcare met all the requirements for monitoring over- and under-utilization.

### *Care Transitions*

CCME reviewed each CICO's program descriptions and policies related to care transitions. The CICOs were required to submit a file of enrollees who were hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. Based on the file received from each CICO, CCME requested a random sample of files for review. Select Health and Wellcare continue to have transition of care issues. Files lacked documentation of the required follow-up assessments, reassessments, PCP notifications, and collaboration with facility Case Management or Discharge Planning staff.

## Overall Recommendations

SCDHHS' requirement that MCOs must achieve NCQA accreditation, as well as its stipulations regarding the number of performance improvement projects that plans must conduct, indicate that the State is committed to a higher level of quality monitoring and accountability for its health plans. CCME recommends that SCDHHS continue to use measures from the annual network adequacy reviews, HEDIS audits, and performance improvement project validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by its health plans. The 2022 - 2023 EQR assessment results, including the identification of health plan strengths, weaknesses, and recommendations, attest to the positive impact of SCDHHS' strategy in monitoring plan compliance, improving quality of care, and aligning healthcare goals with priority topics. The Quality Strategy draft for May 2022 outlined several SCDHHS goals and objectives that align with CMS priority areas. Based on the goals in the Quality Strategy, CCME developed recommendations to allow MCOs to fulfill the objective of the Quality Strategy. *Table 5: SCDHHS Quality Goals* displays the recommendations for each goal.

**Table 5: SCDHHS Quality Goals**

| SCDHHS Quality Goal | Recommendation |
|---|---|
| Ensure the quality and appropriateness of care delivered to members enrolled in managed care | Continue to assess MCO NCQA HEDIS prevention and treatment metrics for attainment of State goal rate (50$^{th}$ percentile or higher); Maintain provisions for each enrollee with a regular source of primary care, access to a contracted network of providers, and support services |
| Assure Medicaid Members have access to care and a quality experience of care | Conduct access studies and time/distance assessments on a continual basis to determine gaps in access for enrollees; continue upgrades to information and data systems relevant to tracking access and availability; maintain current review of access-related utilization metrics |
| Ensure MCO Contract Compliance | Continue to work toward a status of met for all MCP contract standards during annual EQRO audit; Implement corrective action plans as needed to improve compliance wherein required |

| SCDHHS Quality Goal | Recommendation |
|---|---|
| Manage Continuous Performance Improvement | Perform PIP reviews to ensure they achieve improvement in chosen outcomes and monitor for sustainment over time in clinical and nonclinical areas; Retain development of focus project based on priority topic |
| Conduct Targeted Population Quality Activities | Establish strategies and best-practice approaches to conducting activities that focus on sub-populations of members (e.g. postpartum, behavioral health); utilize performance on withhold metrics as method for monitoring and evaluating quality |

*Note. Recommendations are based on SCDHHS Quality Strategy Draft May 2022*

## Assessment of Strengths and Weaknesses

The results of 2022-2023 EQR activities demonstrate that the health plans are qualified and committed to facilitating timely, accessible, and high-quality healthcare for members. The following tables provide an overview of strengths, weaknesses, and recommendations related to quality, timeliness, and access to care identified after the annual reviews.

**Table 6: Evaluation of Quality**

| Strengths Related to Quality |
|---|
| • ATC and Select Health have appropriate policy management processes.<br>• No issues were noted with staffing for key personnel positions and overall staffing for ATC and Select Health.<br>• The MCOs set their claims processing goals to meet or exceed contractual requirements.<br>• The plans have appropriate systems and processes in place to maintain system security and to prevent unauthorized data access or inadvertent disclosure.<br>• Humana also has an employee cybersecurity training program and regularly communicates with staff to remind them of potential threats.<br>• Robust and detailed disaster recovery and/or business continuity plans are in place and are routinely tested.<br>• Each of the MCOs has a Compliance Plan and related policies and procedures to ensure compliance with applicable laws and regulations and to guard against fraud, waste, and abuse.<br>• The Compliance Plans, associated policies and procedures, and Codes of Conduct address topics such as appropriate business conduct, compliance training and education, lines of communication, monitoring and auditing activities, and methods and forums to report suspected or actual compliance issues or fraud, waste, and abuse.<br>• The MCOs have established Pharmacy Lock-in Programs to manage members who are identified as having improper or excessive utilization of pharmacy benefits.<br>• The MCOs have established processes and policies for appropriate use, disclosure, and protection of confidential information.<br>• Written program descriptions and policies provide detailed processes and requirements for initial and ongoing credentialing activities. |

| Strengths Related to Quality |
|---|
| • The MCOs have established committees that use a peer review process to make recommendations for credentialing decisions. The committees meet at defined, routine intervals and are chaired by the health plans' Medical Director or Chief Medical Officer. |
| • Credentialing and recredentialing files for individual practitioners and organizational providers were fully compliant with all requirements. |
| • The health plans monitor for, and take action to address, provider quality of care/service issues and sanctions that would prohibit providers from receiving Federal funds. |
| • The MCO's have established processes for conducting initial and ongoing provider education through various forums. |
| • Appropriate processes are in place for adoption and ongoing review of preventive health and clinical practice guidelines. The adopted guidelines address appropriate topics that are relevant to the member populations. |
| • The health plans have policies defining standards for provider medical record documentation and they educate providers about the standards in a variety of ways. |
| • Routine medical record audits are conducted to assess provider compliance with the medical record documentation standards. |
| • Member Rights and Responsibilities are clearly identified by each MCO in policies, welcome packets, Member Handbooks, Provider Manuals, and on plan websites. |
| • Members are informed of available preventive health and disease management services, available resources, and are encouraged to utilize services as needed. |
| • ATC's and Select Health's QI Program Descriptions were detailed and included all required elements. |
| • Each MCO provided information to members and providers about their QI programs via their websites, Member Handbooks, and Provider Manuals. |
| • Quality committee minutes were well documented. |
| • The MCOs were fully compliant with all information system standards and submitted valid and reportable rates for all HEDIS measures in the scope of the audit. |
| • PIPs were based on analysis of comprehensive aspects of member needs and services, and the rationale for each topic was documented. |
| • All PIPs met the validation requirements and received validation scores within the High Confidence Range. |
| • Results of provider performance are shared through various quality reports, dashboards, provider report cards, and gaps in care reports. |
| • The health plans have detailed UM Program Descriptions and policies that define and describe the UM process and supervision oversight that is provided to staff. |
| • Humana conducts denial letter audits in real time for quality assurance and supervision opportunities as needed for UM reviewers. |
| • Inter Rater Reliability testing results yielded a 90% or higher score for all health plans and exceeded the desired benchmark. |
| • ATC's and Select Health's denial letters were clear and understandable in identifying the rationale for the adverse benefit determination. |
| • Policies thoroughly document processes for pre-delegation assessments, approval of delegation, monitoring, and annual delegation oversight. |

| Strengths Related to Quality |
|---|
| • Annual oversight documentation included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions.<br>• All the CICOs had established policies and processes to conduct appropriate transition of care (TOC) functions as required by the SCDHHS Contract. |

| Weaknesses Related to Quality | Recommendations Related to Quality |
|---|---|
| • For Humana, continued issues with health plan policies were noted. Multiple policy indexes were provided, yet none included all policies that were referenced or discussed. The final policy index submitted for review included policies that did not specify a policy number and/or business owner. Some policies were provided in a draft format, and some policies did not provide a policy number within the document, although the document file name listed a number. | • Humana—Ensure the policy index lists all policies for conducting health plan activities and functions within SC and includes a policy number and business owner for each policy listed. Ensure all policies include an identifying policy number within the policy. Ensure policies are not left in a draft format once the routine review cycle is complete and the policy is approved. |
| • Humana – Discrepancies in health plan documentation, information reported during the onsite visit, and information provided to SCDHHS made it unclear who serves as the contractually required Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager.<br>• Humana – The SCDHHS Contract, Section 2, requires one full time employee (FTE) for both the Member Services Manager position and the Contract Account Manager position. Humana reported that one staff member is serving in both roles.<br>• Humana's Organizational Chart did not display the operational relationships for several key areas, and operational relationships of staff were not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists. | • Humana – Clearly identify the individual who fulfills the role required by the SCDHHS Contract, Section 2 for a health plan Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager.<br>• Humana – Hire a full time Member Services Manager located in SC.<br>• Humana –Revise the Organizational Chart to denote all key staff and their location and the reporting structure for all staff/departments. Staffing Lists and Key Personnel Lists should be consistent with the Organizational Chart and include staff credentials and location. |
| • ATC was noncompliant with its Credentialing Committee policy's requirement that members of the Credentialing Committee must be in-network providers, and documentation of committee member attendance was unclear. | • Ensure the composition of credentialing committees is compliant with all contractual and/or policy requirements. |
| • Humana's Credentials Committee lacks a variety of specialists such as internal medicine, general surgery, neurology, etc. | • Ensure documentation of attendance for voting members of credentialing committees is clear. |
| • Humana's Provider Orientation and Annual Training policy (SC.NNO.007) was not specific to SC and Humana's Provider Manual did not address reassignment of a member to a different PCP. | • Ensure policies reflect processes and requirements specific to SC operations regarding initial and ongoing provider education.<br>• Ensure the Provider Manual includes all information providers need to understand requirements. |
| • Humana requires the member to file a grievance in order to request disenrollment. | • Processes and polices should be revised and remove the requirement that a member must file a grievance in order to request disenrollment. |

| Weaknesses Related to Quality | Recommendations Related to Quality |
|---|---|
| • Humana's definitions of grievance terminology used outdated language and were incomplete. | • The definition for a grievance should match the definition used in the SCDHHS Contract and in federal regulations. |
| • Humana's QI Program Description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships). | • Humana's QI Program Description should be updated and include the program's structure related to the staff assigned to the QI program and their responsibilities. |
| • Humana's Quality Assurance Committee did not include a variety of participating network providers as required by the SCDHHS Contract, Section 15.3.1.2. | • Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee. |
| • Humana's 2021 – 2022 Quality Improvement Evaluation did not include the results of all activities and contained errors. | • Correct the errors in Humana's QI Program Evaluation and include the results of all activities completed and/or an update for the ongoing activities. |
| • Humana's committee responsible for the oversight of the UM Program is incorrect in the 2023 UM Program Description.<br>• Humana's 2023 Pharmacy Program Description identifies Humana Pharmacy Solutions as the pharmacy benefit manager. However, the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager. | • Correct the deficiencies in Humana's UM Program Description and remove the references to the Quality Assessment Committee. Also, verify the pharmacy benefit manager for SC and correct the UM Program Description, Pharmacy Program Description, and/or Humana's website. |
| • Humana's policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 were draft policies that contained tracked changes even though it was recommended last year that these policies be finalized. | • Humana - Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002, finalize the tracked changes, and remove the draft watermark. |
| • Humana and Select Health did not consistently process standard and expedited appeals according to guidelines in their policies and in federal regulations. | • Ensure the appeals process is consistently implemented according to contractual guidelines and federal regulations. |
| • During the current EQR, CCME assessed the degree to which the health plans implemented actions to address deficiencies from the previous EQR and found that Humana did not implement Quality Improvement Plans for all previously identified deficiencies. | • Develop a plan of action to address and correct the deficiencies identified during this and previous EQRs. Include a monitoring component to ensure the plans are implemented timely and all deficiencies are corrected. |
| • Select Health and Wellcare continue to have transition of care issues. Files lacked documentation of the required:<br>○ Collaboration with facility Case Management or Discharge Planning staff. (Select Health, Wellcare)<br>○ PCP notifications of admissions and discharges. (Select Health, Wellcare)<br>○ Attempts to contact members/care giver to compete assessments following discharge. (Wellcare)<br>○ Completions of reassessments following a trigger event. (Select Health) | • Ensure all TOC functions required by the SCDHHS Contract, Sections 2.5 and 2.6 are conducted and clearly documented in the members' files. |

### Table 7: Evaluation of Timeliness

| Strengths<br>Related to Timeliness |
|---|
| • Each MCO met timeliness standards for the acknowledgment and resolution letters for randomly selected grievance files.<br>• All approval files were completed in a timely manner according to contractual requirements.<br>• For Humana and Select Health, documentation submitted for review confirmed timely annual oversight for all applicable delegates and routine reporting and meetings for all delegates. |

| Weaknesses<br>Related to Timeliness | Recommendations<br>Related to Timeliness |
|---|---|
| • Select Health's Provider Manual and policy were inconsistent regarding the timeframe for acknowledging an appeal.<br>• Select Health's Expedited Appeal Request Denial letter template incorrectly states that a verbal appeal request must be followed with a written appeal request. | • Select Health should align the timeframes for acknowledging an appeal in the Provider Manual and in policies. The requirement that a verbal appeal request must be followed with a written appeal request should be removed from all documents. |
| • ATC did not provide annual oversight documentation for one delegate. | • Ensure annual evaluations are conducted for each delegated entity. |

### Table 8: Evaluation of Access to Care

| Strengths Related to Access to Care |
|---|
| • The health plans monitor the adequacy of their networks to ensure appropriate geographic access to PCPs, specialists, hospitals, etc., and contract with all required Status 1 provider types.<br>• Activities are conducted to evaluate and ensure the provider networks can meet the cultural, ethnic, racial, and linguistic needs of members.<br>• The MCOs ensure providers receive education and resources about Cultural Competency.<br>• For the Telephonic Provider Access Studies conducted by CCME, overall access to providers improved for two plans and was sustained at the same rate for one plan.<br>• The MCO's have policies and established processes for monitoring continuity and coordination of care between PCPs and other providers.<br>• Activities conducted to monitor coordination and continuity of care include monitoring HEDIS measures, CAHPS data, member satisfaction survey results, conducting medical record reviews, monitoring disease/case management data, etc.<br>• ATC provided a Member Authorization Form and Member Appeal Form with the adverse benefit determination notices for member convenience.<br>• Humana members can complete appeal requests online and track the process through the online portal.<br>• The health plans' care management staff conducted appropriate care management activities for members in all risk levels.<br>• Select Health's special population programs, such as Bright Start Maternity Care Coordination, Select Health Foster Care Program, and Emergency Diversion, are designed to provide targeted and specialized care to members. |

| Strengths Related to Access to Care |
|---|
| • Processes are in place for monitoring provider compliance with the provision of recommended EPSDT services and immunizations and informing providers of members with services due and care gaps.<br>• All required core benefits are provided to members.<br>• The CICOs maintained an adequate network sufficient to provide enrollees with access to a full range of Home and Community Based services in each geographic area. |

| Weaknesses Related to Access to Care | Recommendations Related to Access to Care |
|---|---|
| • Select Health's Availability of Practitioners and Behavioral Health Provider Availability policies do not address the requirement from the *SCDHHS Contract, Section 6.2.3.1.4* that MCOs must provide a choice of at least two required contracted specialists and/or subspecialists who are accepting new patients within the geographic area. | • Ensure network adequacy policies address all contractual requirements for provider network adequacy. |
| • Humana's PDF versions of the Provider Directories included contradictory information about how members can determine providers that are not accepting new patients and did not indicate any providers who are not accepting new patients, as required by the *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR 438.10 (h) (1) (vi)*. | • Ensure Provider Directories include an indicator of any providers who are not accepting new patients. |
| • Policies addressing appointment access and processes for monitoring provider compliance with those standards did not define the frequency for conducting the mystery shopper call studies (Humana) and did not include all contractual appointment access requirements (Select Health). | • Ensure policies addressing appointment access standards and monitoring processes provide full detail about processes and address all contractually required appointment access standards. |
| • The *SCDHHS Contract, Section 4.2.21.3.2* requires the health plan to authorize a 72-hour emergency supply of medications to members in emergent situations until a prior authorization decision is received. Humana did not have a process outlined to meet this requirement in the Pharmacy Program Description, the Member Handbook, Provider Manual, or in a policy. | • Humana - Include the process followed to authorize a 72-hour supply of medication to members in emergent situations as required by the *SCDHHS Contract, Section 4.2.21.3.2* in a policy and the Pharmacy Program Description. |

## BACKGROUND

As detailed in the *Executive Summary*, CCME as the EQRO conducts an EQR of each MCO participating in the Medicaid Managed Care Program on behalf of SCDHHS. Federal regulations require that EQRs include three mandatory activities: validation of PIPs, validation of PMs, and an evaluation of compliance with state and federal regulations for each health plan.

Federal regulations also allow states to require optional activities that include:

- Validating encounter data
- Administering and validating consumer and provider surveys
- Calculating additional PMs
- Conducting PIPs and quality of care studies

After completing the annual review of the required EQR activities, CCME submits a detailed technical report to SCDHHS and the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths, weaknesses, recommendations for improvement, and the degree to which the plans addressed quality improvement recommendations made during the prior year's review. Annually, CCME prepares a comprehensive technical report for the State which is a compilation of the individual annual review findings. The comprehensive technical report for contract year 2022 through 2023 contains data for: ATC, Humana, and Select Health. The report also includes EQR findings for the plans participating in the Healthy Connections Prime Program under review during this reporting period.

In March 2023, CCME was notified by SCDHHS' Procurement Officer that the State was awarding the new EQR contract to CCME effective May 1, 2023. As a result of this notification, CCME began the process of transitioning from the 2022 – 2023 EQR Contract to the 2023 – 2024 EQR Contract. The reviews for Molina, Healthy Blue, and SC Solutions are not included in this technical report as they will be completed after May 1, 2023. The results of those reviews will be reported in the 2023 – 2024 Annual Technical Report.

## METHODOLOGY

The process used by CCME for EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plan's office. After completing the annual review, CCME submits a detailed technical report to SCDHHS and the health plans. For a health plan not meeting requirements, CCME requires the plan to submit a quality improvement plan for each standard identified as not fully

met. CCME provides technical assistance to each health plan until all deficiencies are corrected.

During this contract year, all onsite visits were conducted virtually due to restrictions from the COVID-19 pandemic. The following table displays the dates of the EQRs conducted for this contract period.

**Table 9: External Quality Review Dates**

| Health Plan | EQR Initiated | Onsite Dates | Reports Submitted |
|---|---|---|---|
| ATC<br>Welcare MMP | 11/7/22 | 2/1/23 – 2/2/23 | 3/2/23 |
| Humana | 1/9/23 | 3/8/23 – 3/9/23 | 4/5/23 |
| Select Health<br>Select Health MMP | 8/9/22 | 11/16/22 – 11/17/22 | 12/15/22 |

# FINDINGS

The plans were evaluated using standards developed by CCME and summarized in the tables for each of the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) indicates the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows are unchanged from the previous review.

## A. Administration

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

Each of the three health plans has established processes for ensuring policies and procedures are reviewed annually and revised when necessary. Staff are educated about new and revised policies by department leadership and policies are housed on electronic platforms for access and tracking purposes.

During the 2022 EQR, deficiencies were identified for Humana regarding the need to reflect an annual policy review process. Details about the 2022 findings and Humana's response are included in *Table 10: Humana's 2022 EQR Deficiencies and Quality Improvement Response*.

**Table 10: Humana's 2022 EQR Deficiencies and Quality Improvement Response**

| Standard | EQR Comments |
|---|---|
| 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. | The 2022 EQR found that policies and procedures are in place indicating that some of Humana's action steps in response to the Readiness Review finding were implemented. However, not at a comprehensive level. Many policies did not reflect consistent annual reviews by all departments. Some policies were last reviewed in 2020. A few examples include Policy (Continuity of Care)-010 last reviewed 11/5/2020, Policy (HPS Audit Discrepancy List Code)-001 last reviewed 11/5/2020, and Policy (Surveillance Policy)-001A last reviewed 9/7/19. Clusters of policies not reviewed within the last twelve months were found for information, technology, and data systems policies.<br><br>*Quality Improvement Plan: Complete a comprehensive review of policies to reflect a current review cycle. Consolidate multiple existing policies with similar content.* |
| **Humana's Response:** Humana will transition from a manual process to an automated process for the storage and review of Policies and Procedures. During the transition, Humana will use one enterprise policy template and meet with business owners to consolidate similar policies.<br><br>**6/24/2022:**<br>June – August 2022—The Medicaid team will meet with the corporate policy team to review policies and determine how to efficiently and effectively condense and combine policies using the Humana enterprise policy template. Policies will be revised according to the new process and sent to the appropriate business, legal, and regulatory compliance reviewers.<br><br>August 2022 – October 2022—Upon final approval, policies will be uploaded to ESP, Humana's Enterprise GRC Tracking system. ESP will send e-mail reminders annually to the assigned reviewers. As a part of the review, business owners will be required to use the enterprise-wide procedure template. The naming convention for each policy will be updated. The ESP Transition Tracker will be used to track progress and avoid any backlog as all policies will be reviewed at once during this project. | |

During the 2023 EQR for Humana, it was evident that Humana improved review processes to include an annual review cycle and that efforts were made to consolidate redundant policies and procedures. However, several versions of the Policy Index were provided, some policies were provided in a draft format, and some policies and procedures did not include the policy name and number within the documents.

The Organizational Charts and supplemental documents for ATC and Select Health identified all key positions required by the *SCDHHS Contract* and clearly delineated departmental oversight to ensure that required health care products and services are provided to members. The following issues were noted for Humana:

- Discrepancies were noted in the information about key personnel provided in the desk materials, reported during the onsite visit, and provided to SCDHHS. It was unclear who fulfilled the requirements of the *SCDHHS Contract, Section 2* for the key positions of Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager.
- The *SCDHHS Contract, Section 2* requires a full-time employee for the Member Services Manager position and for the Contract Account Manager position. Per information provided by Humana, one staff member is serving in both roles.
- The Organizational Chart provided by Humana does not display the operational relationships for key areas such as Member Services, Provider Services, Grievances and Appeals, Network Management, etc. Operational relationships of staff are also not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists.

Each MCO provided a Compliance Plan detailing their programs to ensure compliance with applicable federal and state laws, regulations, accreditation standards, and contractual obligations. Health plan Codes of Conduct describe expectations for conducting business ethically and in accordance with applicable laws and regulations. Comprehensive new-hire and annual compliance training and education are overseen by each MCO's Compliance Department.

Roles and responsibilities of the Compliance Officers and Compliance Committee are included in the Compliance Plans, which, along with related policies, also address lines of communication, initiatives for preventing, detecting, and correcting non-compliance with federal and state requirements, and measures to prevent, detect, and correct fraud, waste, and abuse.

The three MCOs have established Pharmacy Lock-in Programs for managing members who use pharmacy services at a frequency or amount that is not medically necessary. Members are identified through various analysis activities and are restricted to one pharmacy for a defined period. Policies define procedures for identifying members for inclusion in the program, restricting each of the members to one pharmacy, notifying members of their inclusion in the program, and providing additional information and instructions.

Requirements and guidance for ensuring compliance with State and Federal laws and regulations for maintaining the confidentiality of Protected Health Information are found in the MCOs' Compliance Plans, Program Descriptions, Codes of Conduct, policies, procedures, etc. It was confirmed that Humana addressed a deficiency from the 2022 EQR related to inadequate policy information about ensuring the protection of confidential information. Humana retired the deficient policy and created a new policy.

See *Table 11: Humana's 2022 EQR Deficiencies and Quality Improvement Plans* for details about the deficiency and Humana's response.

**Table 11: Humana's 2022 EQR Deficiencies and Quality Improvement Plans**

| Standard | EQR Comments |
|---|---|
| I E. Confidentiality<br>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. | Policy (General Contractual Conditions Confidentiality Policy)-022, states that all personal facts and circumstances concerning members or potential members are treated as privileged and confidential. The policy contains contract language but does not include processes to outline how this is conducted.<br><br>*Quality Improvement Plan: Review Policy (General Contractual Conditions Confidentiality Policy)-022, and include the steps and processes used to safeguard confidential information.* |
| Humana's Response: Humana has retired Policy (General Contractual Conditions Confidentiality Policy)-022. Humana has identified Policy (Information Protection and Acceptable Use) -011 as the appropriate policy to satisfy this requirement. | |

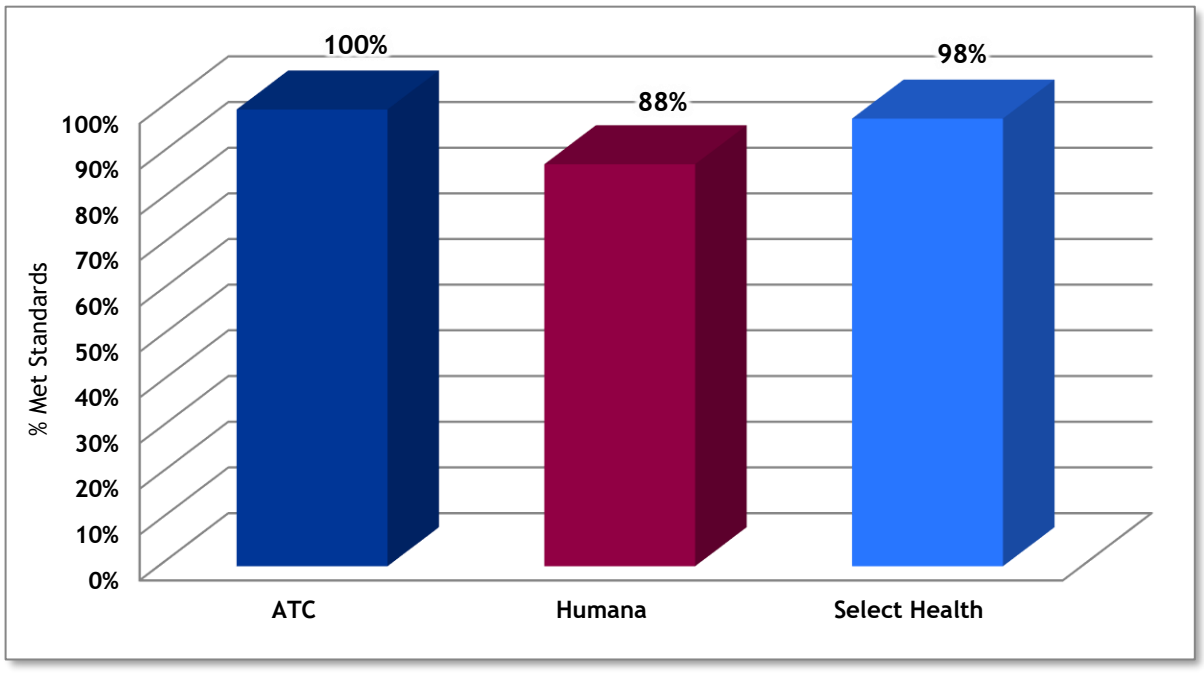
## *Information Management Systems*

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

The reviews of Information Systems Capabilities Assessment (ISCA) documentation confirmed the MCOs are capable of meeting contractual requirements. The plans regularly review and update policies and procedures regarding maintaining data and system security, and routinely test their Disaster Recovery Plans. ATC conducts internal audits to ensure requirements are being met, and regularly contracts with auditors to verify its system controls. Humana provides employees with cybersecurity training and sends frequent security threat reminders to staff. Select Health's disaster recovery capabilities allow data and system operations to failover to a second data center in the event of an outage.

*Figure 2: Administration* standards displays the percentage of standards that were scored as "Met" in the Administration section of the review.

**Figure 2: Administration**




An overview of the scores for the Administration section is illustrated in *Table 12: Administration Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 12: Administration Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| General Approach to Policies and Procedures | | | | |
| The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly | Met | Partially Met | Met | **Strengths:**<br>▶ ATC and Select Health have appropriate policy management processes.<br><br>**Weaknesses:**<br>▶ For Humana, continued issues with health plan policies were noted. Multiple policy indexes were provided, yet none included all policies that were referenced or discussed. The final policy index submitted for review included policies that did not specify a policy number and/or business owner. Some policies were provided in a draft format, and some policies did not provide a policy number within the document, although the document file name listed a number.<br><br>**Recommendations:**<br>• Humana—Ensure the policy index lists all policies for conducting health plan activities and functions within SC and includes a policy number and business owner for each policy listed. Ensure all policies include an identifying policy number within the policy. Ensure policies are not left in a draft format once the routine review cycle is complete and the policy is approved. |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Organizational Chart / Staffing | | | | |
| 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:<br>*Administrator (CEO, COO, Executive Director) | Met | Not Met ↓ | Met | **Strengths:**<br>▶ No issues were noted with staffing for key personnel positions and overall staffing for ATC and Select Health.<br><br>**Weaknesses:**<br>▶ Humana – Discrepancies in health plan documentation, information reported during the onsite visit, and information provided to SCDHHS made it unclear who serves as the contractually required Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager.<br>▶ Humana – The *SCDHHS Contract, Section 2*, requires one full time employee (FTE) for both the Member Services Manager position and the Contract Account Manager position. Humana reported that one staff member is serving in both roles.<br>▶ Humana's Organizational Chart did not display the operational relationships for several key areas, and operational relationships of staff were not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists. |
| Chief Financial Officer (CFO) | Met | Met | Met | |
| *Contract Account Manager | Met | Met | Met | |
| Information Systems personnel<br>Claims and Encounter Manager/ Administrator | Met | Met | Met | |
| Network Management Claims and Encounter Processing Staff | Met | Met | Met | |
| Utilization Management (Coordinator, Manager, Director) | Met | Met | Met | |
| Pharmacy Director | Met | Met | Met | |
| Utilization Review Staff | Met | Met | Met | |
| *Case Management Staff | Met | Met | Met | |
| *Quality Improvement (Coordinator, Manager, Director) | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | = *Quality*<br>= *Timeliness*<br>= *Access to Care* |
|---|---|---|---|---|
| Quality Assessment and Performance Improvement Staff | Met | Met | Met | **Recommendations:**<br>• Humana – Clearly identify the individual who fulfills the role required by the SCDHHS Contract, Section 2 for a health plan Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager.<br>• Humana – Hire a full time Member Services Manager located in SC.<br>• Humana –Revise the Organizational Chart to denote all key staff and their location and the reporting structure for all staff/departments. Staffing Lists and Key Personnel Lists should be consistent with the Organizational Chart and include staff credentials and location. |
| *Provider Services Manager | Met | Not Met ↓ | Met | |
| *Provider Services Staff | Met | Met | Met | |
| *Member Services Manager | Met | Not Met ↓ | Met | |
| Member Services Staff | Met | Met | Met | |
| *Medical Director | Met | Met | Met | |
| *Compliance Officer | Met | Met | Met | |
| Program Integrity Coordinator | Met | Met | Met | |
| Compliance /Program Integrity Staff | Met | Met | Met | |
| *Interagency Liaison | Met | Met | Met | |
| Legal Staff | Met | Met | Met | |
| *Behavioral Health Director | Met | Met | Met | |
| *Program Integrity FWA Investigative/Review Staff | Met | Met | Met | |
| Operational relationships of MCO staff are clearly delineated | Met | Partially Met ↓ | Met | |
| Management Information Systems<br>*42 CFR § 438.242, 42 CFR § 457.1233 (d)* | | | | |
| The MCO processes provider claims in an accurate and timely fashion | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The MCO is capable of accepting and generating HIPAA compliant electronic transactions | Met | Met | Met | **Strengths:**<br>▶ The MCOs set their claims processing goals to meet or exceed contractual requirements.<br>▶ The plans have appropriate systems and processes in place to maintain system security and to prevent unauthorized data access or inadvertent disclosure.<br>▶ Humana also has an employee cybersecurity training program and regularly communicates with staff to remind them of potential threats.<br>▶ Robust and detailed disaster recovery and/or business continuity plans are in place and are routinely tested. |
| The MCO tracks enrollment and demographic data and links it to the provider base | Met | Met | Met | |
| 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 | Met | Met | Met | |
| The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract | Met | Met | Met | |
| The MCO has policies, procedures and/or processes in place for addressing system and information security and access management | Met | Met | Met | |
| The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented | Met | Met | Met | |
| Compliance/Program Integrity | | | | |
| The MCO has a Compliance Plan to guard against fraud and abuse | Met | Met | Met | **Strengths:**<br>▶ Each of the MCOs has a Compliance Plan and related policies and procedures to ensure compliance with applicable laws and regulations and to guard against fraud, waste, and abuse.<br>▶ The Compliance Plans, associated policies and procedures, and Codes of Conduct address topics such as appropriate business conduct, compliance |
| The Compliance Plan and/or policies and procedures address all requirements | Met | Met | Met | |
| The MCO has an established committee responsible for oversight of the Compliance Program | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care* |
|---|---|---|---|---|
| The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse | Met | Met | Met | training and education, lines of communication, monitoring and auditing activities, and methods and forums to report suspected or actual compliance issues or fraud, waste, and abuse.<br>▶ The MCOs have established Pharmacy Lock-in Programs to manage members who are identified as having improper or excessive utilization of pharmacy benefits. |
| The MCO's policies and procedures define how investigations of all reported incidents are conducted | Met | Met | Met | |
| The MCO has processes in place for provider payment suspensions and recoupments of overpayments | Met | Met | Met | |
| The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP) | Met | Met | Met | |
| Confidentiality<br>*42 CFR § 438.224* | | | | |
| The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy | Met | Met ↑ | Met | **Strengths:**<br>▶ The MCOs have established processes and policies for appropriate use, disclosure, and protection of confidential information. |

## B. Provider Services

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

The review of Provider Services encompasses processes for credentialing and recredentialing, ensuring network adequacy, initial and ongoing provider education, adopting and disseminating preventive health and clinical practice guidelines, ensuring continuity of care, and assessing practitioner compliance with medical record documentation standards.

### *Credentialing and Recredentialing*

*42 CFR § 438.214, 42 CFR § 457.1233(a)*

The MCOs have established committees that use a peer review process to make recommendations for credentialing decisions. The committees meet at defined, routine intervals and are chaired by the health plans' Medical Director or Chief Medical Officer. Documentation of the requirements for the committees was reviewed, as well as committee minutes. No issues were identified with Select Health's Credentialing Committee. The following issues were noted for ATC and Humana:

- For ATC, Policy CC.CRED.03, Credentialing Committee, states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers." However, the 2022 committee roster indicates one external practitioner member of the committee, who is not an employee of ATC or Centene, is not a network provider. Also, documentation of member attendance was unclear in the Credentialing Committee minutes due to a lack of a key defining the symbols/indicators used to document attendance.
- Humana's Credentials Committee includes the practitioner types required by the Committee Charter; however, the committee lacks a variety of specialists such as internal medicine, general surgery, and/or neurology.

Each of the health plans has written program descriptions that provide an overview of the credentialing program and policies that provide detailed processes and requirements for initial and ongoing credentialing activities. The policies also address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, and sanction monitoring. ATC's policies define the timeframe for processing practitioner credentialing applications and circumstances under which a practitioner may appeal the denial of a credentialing application, but the policies did not address these elements for organizational providers.

The current EQR confirmed Humana appropriately addressed the QIP from the previous EQR related to errors/omissions from the credentialing policies. See *Table 13: 2022*

*Provider Credentialing and Selection QIP* Items for the previously identified issues and Humana's response.

**Table 13: 2022 Provider Credentialing and Selection QIP Items – Humana**

| Standard | EQR Comments |
|---|---|
| **II. A. Credentialing and Recredentialing** | |
| 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. | Humana has a written Credentialing & Recredentialing Program Description. The enterprise-wide CORE Credentialing and Recredentialing (23rd ed)-001A policy addresses general credentialing and recredentialing requirements for individual practitioners and organizational providers. Requirements specific to South Carolina Medicaid provider credentialing and recredentialing are found in Policy (CORE Credentialing and Recredentialing)-001.<br>The policies address most credentialing and recredentialing elements, including the scope of practitioners who must be credentialed, information to be collected and verified by the MCO, acceptable verification sources, the review and determination process, provider appeal rights, and requirements for non-discrimination against providers in high risk/high cost patient specialties. However, the South Carolina requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001.<br>*Quality Improvement Plan: Revise Policy (CORE Credentialing and Recredentialing)-001 to specify that querying the SCDHHS Termination for Cause List is a required element for initial credentialing and recredentialing for all practitioners and organizational providers.* |
| **Humana's Response:** Humana revised Policy (CORE Credentialing and Re-credentialing)-001 to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers.<br>**5/17/2022:** Humana revised Policy (CORE Credentialing and Re-credentialing)-001 to also include a query of the Termination for Cause List for organizational providers (page 7). | |

As part of the EQR, CCME reviewed a sample of initial credentialing files and recredentialing files for practitioners and organizational providers. Humana's and Select Health's files for practitioners and organizational providers reflected full compliance with credentialing and recredentialing requirements. For ATC, no issues were noted in the initial credentialing and recredentialing files for practitioners. For organizational providers, one file for a rural health clinic did not include a SC Department of Health and Environmental Control license which was stated in ATC policy as a requirement.

The file review confirmed Humana corrected issues identified during the previous EQR. *Table 14: 2022 Provider Credentialing and Selection QIP Items - Humana* lists the previously identified issues and Humana's response.

**Table 14: 2022 Provider Credentialing and Selection QIP Items - Humana**

| Standard | EQR Comments |
|---|---|
| **II. A. Credentialing and Recredentialing** | |
| 3. The credentialing process includes all elements required by the contract and by the MCO's internal policies. | Review of initial credentialing provider files submitted by Humana revealed:<br>•For 14 of 16 files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This is a repeat finding from the Readiness Review.<br>•Two initial credentialing files for nurse practitioners were submitted. Both files were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*. This is a repeated finding from the Readiness Review.<br>*Quality Improvement Plan: Ensure practitioner credentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician.* |
| **Humana's Response:** Humana re-trained the Credentialing Operations staff on 04/26/2022. Humana has also updated the credentialing process to allow the committee approval letter to be generated the same day as the committee credentialing approval date. This process change will go - live 5/12/2022.<br>5/17/2022: The projected timeframe to complete the collection of collaborative agreements for nurse practitioners is 7/30/2022. Please see the attached SC Medicaid Nurse Practitioner Collaborative Agreement Collection Plan. | |
| 3.1 Verification of information on the applicant, including:<br><br>3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List; | None of the 16 initial credentialing provider files included evidence of querying the SCDHHS SC Providers Terminated for Cause List. This was discussed during the onsite, and Humana provided the following response after completion of the onsite: "I have confirmed the verification of the "termed for cause list" was not completed for any of the credentialing and recredentialing files reviewed during the audit period. I acknowledge this is a gap in our existing process and we are working to close this gap immediately. Collection and verification of the "termed for cause list" distributed by SC DHHS is a planned area of focus that we will be re-educating and auditing more stringently going forward."<br>*Quality Improvement Plan: Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at initial credentialing and that the credentialing files include evidence of the query as well as the date of the query.* |

| Standard | EQR Comments |
|---|---|
| **Humana's Response:** Humana revised Policy (CORE Credentialing and Re-credentialing)-001, Policy (CORE Sanctions) -002, and the Provider Sanctions Process CAQH Debarment document to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers. **5/17/2022:** The inclusion of querying the SC Providers Terminated for Cause List went live on 4/11/2022. The existing SC Medicaid providers were screened against the Terminated for Cause List on 04/11/2022 and again on 05/02/2022. This will be a permanent part of the process moving forward. | |
| 3.1.12 Query of Social Security Administration's Death Master File (SSDMF); | Four initial credentialing files did not include evidence of the query of the Social Security Administration's Death Master File. Evidence of queries of the Social Security Death Master File were submitted after the onsite for the four files in question; however, the queries indicate they were conducted on March 3, 2022, and not prior to the initial credentialing determination for the four providers.<br>*Quality Improvement Plan: Ensure all initial practitioner credentialing files include evidence of querying the Social Security Death Master File prior to the initial credentialing determination.* |
| **Humana's Response:** Humana re-trained the Credentialing Operations staff on 04/26/2022 ensuring the verification of the Social Security Death Master File at credentialing and re-credentialing. | |
| 4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies. | Review of recredentialing provider files submitted by Humana revealed:<br>•For 14 of 16 files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee approval date.<br>•Two recredentialing files for nurse practitioners were submitted. Both files were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.<br>*Quality Improvement Plan: Ensure practitioner credentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician.* |
| **Humana's Response:** Humana re-trained the Credentialing Operations staff on 04/26/2022. Humana has also updated the credentialing process to allow the committee approval letter to be generated the same day as the committee credentialing approval date. This process change will go - live on 5/12/2022. **5/17/2022:** The projected timeframe to complete the collection of collaborative agreements for nurse practitioners is 7/30/2022. Please see the attached SC Medicaid Nurse Practitioner Collaborative Agreement Collection Plan. | |
| 4.2 Verification of information on the applicant, including:<br><br>4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List; | Zero of 16 recredentialing provider files included evidence of querying the SC Providers Terminated for Cause List. This was discussed during the onsite, and Humana provided the following response after completion of the onsite:<br>"I have confirmed the verification of the "termed for cause list" was not completed for any of the credentialing and recredentialing files reviewed during the audit period. I acknowledge this is a gap in our |

| Standard | EQR Comments |
|---|---|
| | existing process and we are working to close this gap immediately. Collection and verification of the "termed for cause list" distributed by SC DHHS is a planned area of focus that we will be re-educating and auditing more stringently going forward."<br>*Quality Improvement Plan: Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at recredentialing and that the recredentialing files include evidence of the query as well as the date of the query.* |
| **Humana's Response:** Humana re-trained the Credentialing Operations staff on 04/26/2022. Humana revised Policy (CORE Credentialing and Re-credentialing)-001, Policy (CORE Sanctions) -002, and the Provider Sanctions Process Debarment document to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers.<br>**5/17/2022:** The inclusion of querying the SC Providers Terminated for Cause List went live on 4/11/2022. The existing SC Medicaid providers were screened against the Terminated for Cause List on 04/11/2022 and again on 05/02/2022. | |
| 4.2.11 Query of the Social Security Administration's Death Master File (SSDMF); | Six recredentialing files did not include evidence of the query of the Social Security Administration's Death Master File.<br>Evidence of queries of the Social Security Death Master File were submitted after the onsite for the six files in question; however, the queries indicate they were conducted on March 3, 2022, and not prior to the recredentialing determination for the six providers.<br>*Quality Improvement Plan: Ensure all practitioner recredentialing files include evidence of querying the Social Security Death Master File prior to the recredentialing determination.* |
| **Humana's Response:** Humana re-trained the Credentialing Operations staff on 04/26/2022 ensuring the verification of the Social Security Death Master File at credentialing and re-credentialing. | |
| 6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities. | Thirteen initial credentialing files were submitted for organizational providers. The following issues were noted:<br>•For 12 initial credentialing files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review.<br>•The query of the SCDHHS Excluded Provider's Report was conducted three months after the determination date for one file.<br>•None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.<br>Fifteen recredentialing files were submitted for organizational providers. The following issues were noted:<br>•For 12 recredentialing files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review.<br>•None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.<br>*Quality Improvement Plan: Ensure organizational provider credentialing and recredentialing files contain evidence that* |

| Standard | EQR Comments |
|---|---|
| | *credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every organizational provider at initial credentialing and recredentialing, and that the files include evidence of the query as well as the date of the query.* |
| **Humana's Response:** Humana revised Policy (CORE Credentialing and Re-credentialing)-001, Policy (CORE Sanctions) -002, and the Provider Sanctions Process Debarment document to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers. Humana has also updated the credentialing process to allow the committee approval letter to be generated the same day as the committee credentialing approval date.<br>**5/17/2022:** The inclusion of querying the SC Providers Terminated for Cause List went live on 4/11/2022. The existing SC Medicaid providers were screened against the Terminated for Cause List on 04/11/2022 and again on 05/02/2022. | |

To ensure that no payments are made to individual providers or entities who are excluded from participation in any Federal health care program, the health plans conduct ongoing monitoring of network providers for sanctions and exclusions. The plans also investigate and take action when there are concerns with a provider's quality of care or service. For the previous EQR, issues were noted with Humana's policy for conducting monthly monitoring for sanctions. The current review confirmed Humana appropriately addressed this issue. See *Table 15: 2022 Provider Credentialing and Selection QIP Items - Humana* for details about the deficiency and Humana's response.

**Table 15: 2022 Provider Credentialing and Selection QIP Items – Humana**

| Standard | EQR Comments |
|---|---|
| **II. A. Credentialing and Recredentialing** | |
| 7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds. | Policy (Core Sanctions Policy)-002 states "Humana monitors practitioner sanctions, exclusions, and debarments between recredentialing cycles and ensures that corrective actions are undertaken and effective when it identifies occurrences of such instances." Ongoing monitoring and appropriate interventions up to and including removal from the network are implemented by collecting and reviewing Medicare/Medicaid sanctions and exclusions, licensure sanctions/limitations, and identified adverse events within 30 calendar days of release.<br>Credentialing staff are notified of publications that include a weekly sanction pull from:<br>•Council for Affordable Quality Healthcare (CAQH)—includes providers with state license sanctions and exclusions/sanctions |

| Standard | EQR Comments |
|---|---|
| | from the Office of Inspector General (OIG) List of Excluded individuals/Entities (LEIE)<br>•System for Award Management (SAM) publications<br>•State Medicaid exclusion notifications<br>•Office of Personnel Management (OPM) debarment reports<br>The policy states that at least every 30 days, credentialing staff review the South Carolina Excluded Providers list for newly excluded providers. However, the policy does not include that the SCDHHS SC Providers Terminated for Cause List is also monitored.<br>Credentialing staff search the Provider Master Data Management (PMDM) system to confirm the identity of the sanctioned provider. Medicaid practitioners will have action taken no later than 48 hours of discovery of the sanction. Once a provider is confirmed, documentation is saved, and a certified letter is drafted to notify the provider of the termination.<br>*Quality Improvement Plan: Revise Policy (Core Sanctions Policy)-002 to include the SCDHHS SC Provider Terminated for Cause List as a required monthly monitoring element.* |
| **Humana's Response:** Humana revised Policy (CORE Sanctions) -002 to include the SCDHHS Termination for Cause List as a required query. | |

## *Adequacy of the Provider Network*

*42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 438.10(h), 42 CFR § 457.1230(a) (b), 42 CFR § 457.1230(b)*

Processes are in place for monitoring the geographic adequacy of the MCOs' provider networks. ATC and Select Health conducts routine Geo Access mapping to determine the number and geographic distribution of providers using standards defined by SCDHHS. Humana reported that geographic access maps are not created; however, the health plan uses Power BI and other data analytics tools to generate multiple reports each month to identify any gaps in the geographic adequacy of the network. When evaluating network adequacy, the plans consider additional factors such as member grievances related to practitioner access, member to provider ratios, out of network requests, etc. When network gaps are identified, the plans identify the cause, any barriers, and opportunities for improvement, and take action to address the gaps. It was noted that ATC has expanded its network and is focusing on adding additional pediatrics, obstetrics/gynecology, and ambulatory surgery centers. Humana is working to add hematology/oncology providers.

The MCOs contract with all required Status 1 provider types. *Table 16: Previous Adequacy of the Provider Network QIP Items – ATC* lists a repeat issue identified during

the 2021 EQR related to omission of a SCDHHS required Status 1 provider type from ATC's Geo Access mapping conducted to assess network adequacy. The findings of the current EQR reflect ATC corrected this deficiency.

**Table 16: Previous EQR Previous Adequacy of the Provider Network QIP - ATC**

| Standard | EQR Comments |
|---|---|
| **II B. Adequacy of the Provider Network** | |
| 1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually. | As stated in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC measures practitioner type and availability annually. Also included in the assessment of the network are survey results and grievance data regarding satisfaction with practitioner availability. Results are reported and reviewed by the Quality Committee which makes recommendations to address any identified deficiencies.<br>The Geo Access mapping dated November 10, 2021, did not include results for all SCDHHS-designated Status 1 provider types as it did not include Pediatrics practitioners. This is a repeat finding from the previous EQR. This finding was discussed with ATC staff during the onsite, and additional information was provided that "when GEO Access Reports were generated, Pediatrics was inadvertently omitted from the report."<br>*Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all SCDHHS-designated Status 1 providers. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* |
| **ATC's Response**: A checklist of all status one providers has been developed to ensure when reviewing the reports, we capture all providers as required by SCDHHS. | |

In addition to monitoring geographic adequacy, the MCOs evaluate provider compliance with appointment access standards by conducting routine "secret shopper" call studies. The plans also consider additional factors, such as member satisfaction survey results and complaint/grievance data. The plans analyze the results and take action to address any identified issues. No issues were noted for ATC and Select Health. For Humana, the Executive Summary Report to Humana Healthy Horizons in South Carolina Quality Assurance Committee Provider Access and Availability Study incorrectly indicated that there is no contractual requirement for immediate/emergent care specialty visits and that the question would be excluded from future surveys. CCME reminded Humana of the appointment access requirement found in the *SCDHHS Contract, Section 6.2.3.1.5.1* for emergent visits with specialists.

Findings of the current EQR confirmed Select Health addressed the deficiency identified during the 2021 EQR related to appointment access parameters used to assess provider compliance. See *Table 17: 2021 Practitioner Accessibility QIP Items – Select Health*.

**Table 17: 2021 Practitioner Accessibility QIP Items – Select Health**

| Standard | EQR Comments |
|---|---|
| **II B. Adequacy of the Provider Network** | |
| 3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements. | The Select Health of South Carolina Accessibility of Services report for 2021, page three, indicates the access standard for regular/routine PCP appointments is 10 business days, where policy NM 159.203 lists the timeframe as 4-6 weeks, as stated in the *SCDHHS Contract, Section 6.2.2.3*. During the onsite, this finding was discussed, and Select Health later provided the following information via email: "In regards to the discrepancy found in the routine PCP appointment access parameter between Policy NM 159.203 and the Select Health of South Carolina Accessibility of Services report for 2021, the report is correct and the survey was completed using a 10 business day timeframe which is within the 4 to 6 weeks contract requirement and it meets our policy requirements as well."<br>This 10 business day timeframe is stricter than the routine PCP appointment standard documented in the Provider Manual, page 51, to which providers are informed that they must adhere.<br>*Quality Improvement Plan: Ensure appointment access studies are conducted using the parameters that PCPs are instructed they must comply with.* |
| **Select Health Response:** Select Health of South Carolina (SHSC) will ensure that the appointment access studies are conducted using the parameters that PCPs are instructed they must comply with (i.e., 4 to 6 weeks). The SHSC Accessibility of Services report will reflect this timeframe going forward. | |

To ensure the network can meet members' cultural, language, and other special needs, the plans routinely assess the cultural, ethnic, racial, and linguistic needs of their members. The plans also collect corresponding provider information and monitor member satisfaction survey results, grievance data, etc. The results of these activities are used to make adjustments in the network as needed. Each of the health plans provides cultural competency education and resources to their providers. It was noted that Select Health's website included non-functional links for training information about cultural competency.

### *Provider Access and Availability Study*

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

As a part of the annual review process for all plans, CCME conducted a Telephonic Provider Access Study focusing on PCPs. CCME requested and received a list of network

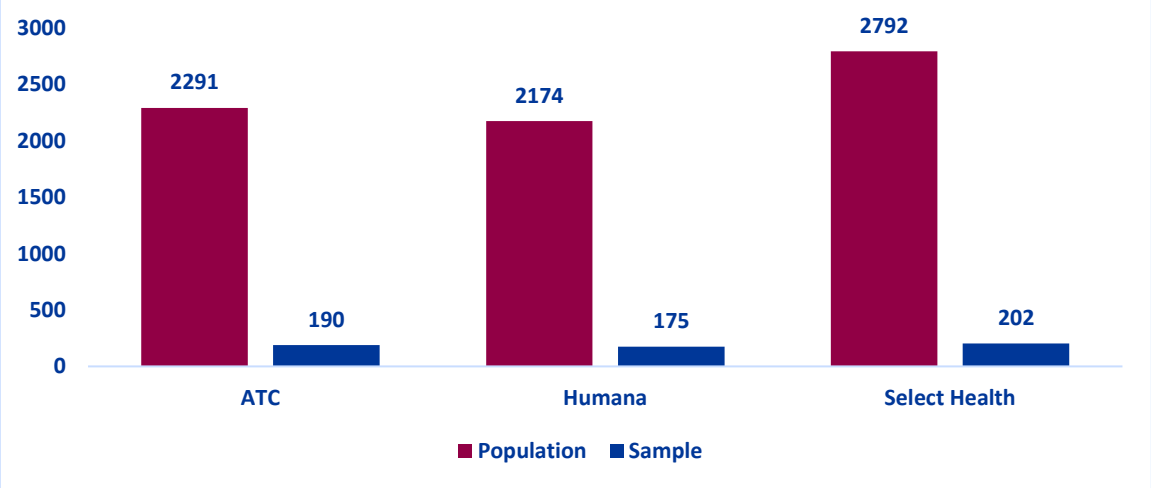
providers and contact information from each of the health plans. From each list, CCME defined a population of PCPs and selected a statistically relevant sample of providers for the study. CCME attempted to contact these providers to ask a series of questions about the access plan members have to their PCPs.

Due to the timing of this report, the findings for ATC, Humana, and Select Health are presented. All three plans received a "Met" score for the standard requiring an improvement in the results of the Telephonic Provider Access Study. The following charts summarize the findings and compare the three plans surveyed.

### *Population and Sample Size*

From the three MCOs reviewed, CCME identified a total population of 7,257 PCPs. From each plan's population, CCME randomly selected a total of 567 providers, as shown in *Figure 3: Population and Sample Sizes for Each Plan*.

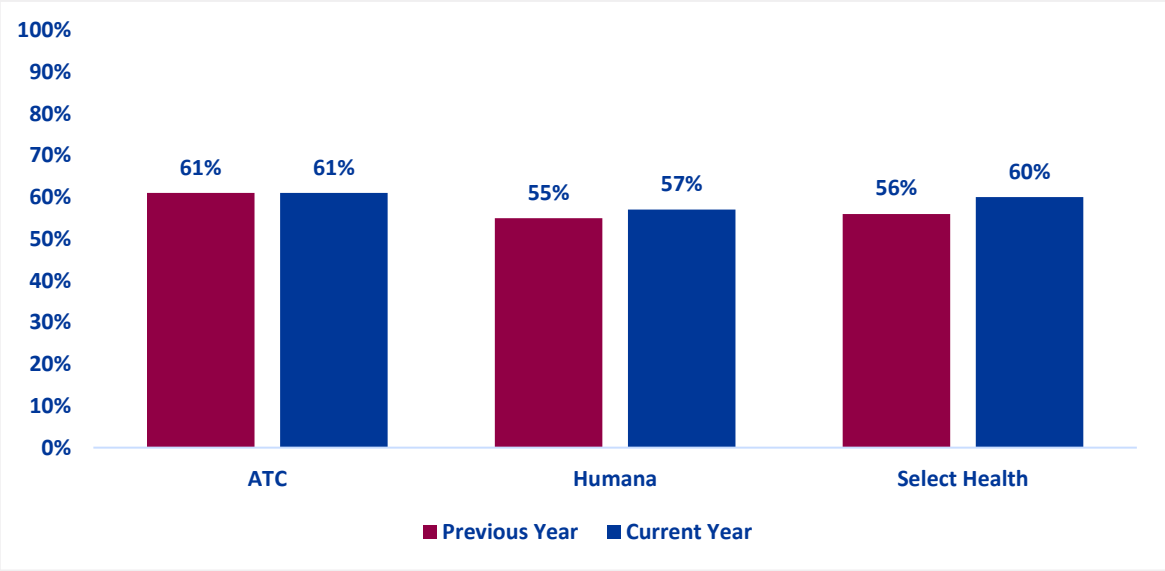
**Figure 3: Population and Sample Sizes for Each Plan**




### *Successfully Answered Calls*

The percentage of successfully answered calls ranges from 57% to 61% for the three plans reported. As shown in *Figure 4*, the largest improvement over last year's study was a 4% increase. One plan sustained the success rate from last year, and one plan had a 2% increase in the success rate.

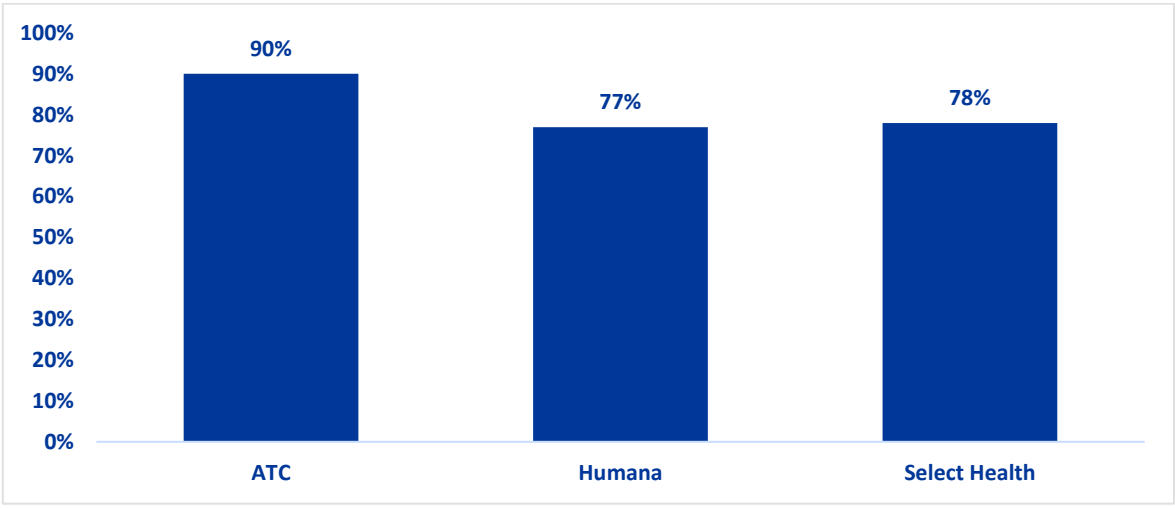
Figure 4: Percentage of Successfully Answered Calls




## *Currently Accepting the Plan*

The range of providers reporting that they accept the plan was 77% to 90%. See *Figure 5: Percentage of Providers Accepting Medicaid Patients*.

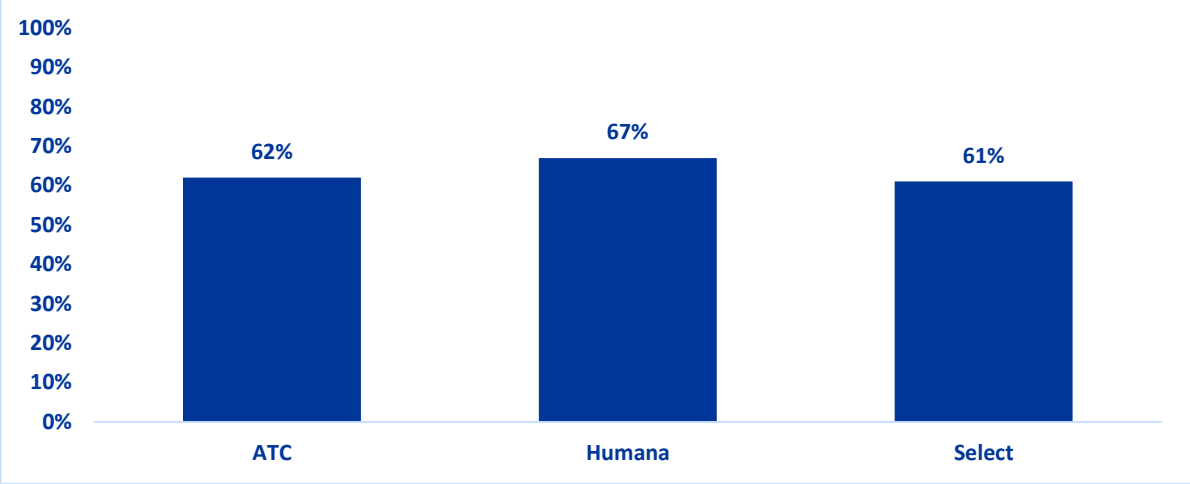
Figure 5: Percentage of Providers Accepting the Plan




## *Accepting Medicaid Patients*

Providers accepting new patients ranged from 61% to 67% across the three plans reported. In comparison to the previous year, this is a decline in the rate for all three plans. See *Figure 6: Percentage of Providers Accepting Medicaid Patients*.

Figure 6: Percentage of Providers Accepting Medicaid Patients




## *Summary of Study Findings*

For the three plans, overall access to providers improved for two plans and was sustained at the same rate for one plan in the Telephonic Provider Access Study. The percentage of providers that are currently accepting the plans was reported to have a range from 77% to 90%. The highest rate was reported by ATC. All three plans had similar rates for providers accepting new Medicaid patients with a range from 61% to 67%, although this metric declined from the previous year for all three plans. All three plans reported met the standard for improvement or sustainment from the previous Telephonic Provider Access Study results.

*Tables 18* and 19 below list the findings from the previous Provider Access and Availability Studies for ATC and Select Health and each plan's response to those findings.

Table 18: 2021 Adequacy of the Provider Network QIP Items – ATC

| Standard | EQR Comments |
|---|---|
| II B. Adequacy of the Provider Network | |
| 3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results. | As part of the annual EQR process for ATC, a provider access study was conducted focusing on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,268 unique PCPs was found. A sample of 178 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 that members have with the contracted providers. |

| Standard | EQR Comments |
|---|---|
| | For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time (96 out of 157) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's result of 73%, this year's study had a decrease in successful calls at 61% (p=.0257), representing a statistically significant decrease of 12%.<br>*Quality Improvement Plan: Determine additional methods to maintain updated information, such as current provider practice locations, in provider files. Increase E-Verify usage to more than four times per year to increase accuracy of provider files.* |
| **ATC's Response:** The LexisNexis (vendor) E-Verify campaigns currently run on a three-month cycle with reminders sent via USPS and email. Absolute Total Care will access LexisNexis capabilities and the appropriateness of increasing E-Verify usage to more than four times per year to increase accuracy of provider files. In addition, Absolute Total Care will be working with LexisNexis to evaluate targeted providers and data feeds to support the current campaign schedule.<br>Provider Relations will continue to educate practitioners on the process to submit changes timely to health plan to improve the accuracy of the information to ensure Physician Directory database is current. Onsite and/or virtual educational activities will occur during New Provider Orientations, monthly/quarterly provider joint operating committee meetings, quarterly town hall sessions, etc. Additional reminders will be deployed in the quarterly provider newsletter in the *"Updating Provider Directory Information"* section starting in 2022. Provider Relations and Provider Data Management will provide practitioner load reports to provider groups/physician offices to review for accuracy of data provided. Corrections identified by provider groups/physician offices will be updated in the Physician Directory database. Process was implemented in Q4 2021 and is on-going.<br>Provider Relations staff to be trained/re-trained on completing real-time demographic updates in the Provider Data Update (PDU) tool. Staff will complete the updates upon notification of phone number changes and other updates permitted via PDU tool. Plan is exploring the opportunity to have Provider Relations conduct random call audits monthly to providers by assignment to confirm accuracy of phone numbers. | |

**Table 19: 2021 Telephonic Provider Access Study QIP Items – Select Health**

| Standard | EQR Comments |
|---|---|
| **II B. Adequacy of the Provider Network** | |
| 3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results. | As part of the annual EQR process for Select Health Plan, a provider access study was conducted focusing on primary care providers. From a list of current providers supplied by Select Health, a population of 2,780 unique PCPs was identified, and a sample of 190 providers was randomly selected for the Access Study. Attempts were made to contact the providers to ask a series of questions regarding the access members have to the contracted providers.<br>Calls were successfully answered 56% of the time (94 of 167) when omitting calls answered by voicemail messaging services. The success |

| Standard | EQR Comments |
|---|---|
| | rate is a significant reduction from last year's rate of 77% and is a statistically significant decline (p <.001).<br>For those not answered successfully (n=73 calls), 53 (73%) were due to the physician no longer being active at the location.<br>*Quality Improvement Plan: Determine barriers to updating provider status as active. Continue to review records to ensure provider contact information is updated and initiate new interventions to update provider information.* |
| **Select Health's Response:** SHSC notes the following barriers to updating the provider's status as active:<br>• Often, providers request that each practitioner be listed at each of their locations to provide coverage at multiple locations. The Plan has up to 30 days to make corrections on updates and terminations upon provider notifications. In many instances, providers do not notify SHSC in a timely manner of practitioner/group terminations, address changes, etc. Providers have expressed that they are experiencing staffing shortages and increased administrative burden due to the pandemic.<br>SHSC notes the following interventions for 2022:<br>• SHSC continuously strives to ensure that all provider information is accurate and updated in a timely manner. Our Account Executives review the information of a significant number of providers to determine accuracy and update provider information when needed, these reviews take place on a monthly basis. While the reviews are not exclusive to PCPs, for 2022 SHSC will increase the focus on PCPs. Select Health's goal is to review 60 percent of our PCP pool during 2022. Findings are tracked and reported out during Select Health's monthly provider data workgroup.<br>• SHSC's 2022 annual Online Provider Directory Validation Survey will focus on reviewing provider information at the individual provider level as opposed to the group level in an effort to improve its provider information accuracy.<br>Lastly, in an effort to emphasize the importance of receiving timely provider information updates, SHSC will include the process providers are to follow to communicate these updates to the plan in our regional provider training presentations. | |

## *Provider Education*

*42 CFR § 438.414, 42 CFR § 457.1260*

The MCOs have policies, training plans, and other documentation that describe processes for initial and ongoing provider education. Humana's Provider Orientation and Annual Training Policy (SC.NNO.007) provides an overview of new provider orientation but is not specific to SC and references a New Provider Orientation Checklist that the health plan confirmed is not used. Humana responded to this discussion of this policy with a statement that the policy "is generic to all markets and all lines of business."

*Table 20: 2022 Provider Education QIP Items* – Humana lists issues noted during the previous EQR with Humana's policy for provider education, as well as Humana's response. The policy provided for the previous EQR has been retired and a new policy was created. The new policy (Policy SC.NNO.007, Provider Orientation and Annual Training), continued to reference a New Provider Orientation Checklist that Humana confirmed is not used. This was a deficiency identified during the previous EQR.

**Table 20: 2022 Provider Education QIP Items – Humana**

| Standard | EQR Comments |
|---|---|
| **II C. Provider Education** | |
| 1. The MCO formulates and acts within policies and procedures related to initial education of providers. | Policy and Procedure (Provider Training)-009 describes processes for initial and ongoing provider education, and includes topics covered during orientation and training sessions. Provider orientation is conducted within 30 days of a provider's contract effective date. Ongoing provider education training is conducted throughout the year for program changes via monthly in-services with PCP offices, ad hoc provider meetings and webinars, periodic newsletters, annual compliance training, etc.<br><br>Issues identified in Policy (Provider Training)-009 include:<br>•Page 2, item #1 states, "If necessary to accommodate preferences of office staff, the below may be mailed." However, the policy does not list what may be mailed.<br>•Page 3 of the policy lists materials that are available on the website. The list includes the "Louisiana Medicaid provider manual." This is an issue CCME noted during the 2021 Readiness Review and recommended that Humana correct.<br>•The policy makes multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist These references were noted in item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four. Humana confirmed that a New Provider Orientation Checklist and New Provider Orientation and Provider Training Checklist are not used.<br><br>*Quality Improvement Plan: Revise Policy (Provider Training)-009 to include items that may be mailed to providers (page two, item #1). Also, remove the reference to the Louisiana Medicaid provider manual (page 3) and remove references to the New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist (item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four).* |
| **Humana's Response:** Humana has retired (Provider Training)-009 and updated policy (Provider Training) -001. Humana ensured there are no references to the Louisiana Medicaid Provider Manual or the Provider Orientation Checklist/New Provider Orientation Checklist. | |
| 2. Initial provider education includes:<br>2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS; | The Provider Orientation and Training Slides document addresses covered services, member costs, EPSDT services, telehealth visits, pharmacy benefits, excluded services, and added benefits.<br><br>Information about member benefits is included in the Provider Manual; however, the following issues were identified:<br>•Page nine states audiological services are covered but does not provide limitations to this coverage or indicate hearing aids for members 21 and over are not covered. See the *SCDHHS Contract, Section 4.2.4.* |

| Standard | EQR Comments |
|---|---|
| | •Page nine states chiropractic services are covered and limited to manual manipulation of the spine to correct subluxation. However, it does not include the limitation of six visits per year. See the *SCDHHS Contract, Section 4.2.6.*<br>•Pages 28 states Humana uses the Universal BabyNet Prior Authorization Form but does not provide any information about the BabyNet program. See the *SCDHHS Contract, Appendix E.*<br>•The Provider Manual does not indicate that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. See the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18.* Additionally, this benefit is not included in Policy (UM – Core Benefits and Services)-007.<br>*Quality Improvement Plan: Revise the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. Revise Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting.* |
| **Humana's Response:** Humana revised the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. Humana also revised Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting. | |

ATC and Select Health conduct initial orientation sessions within approximately 30 days of the contract effective date. Humana sends an initial welcome letter followed by a welcome call within 30 days and provides links to provider resources. One-on-one training is offered if the provider desires. Ongoing provider education is accomplished via one-on-one provider meetings, regional provider training sessions, Provider Manual Updates, newsletters, websites, and provider portals.

Provider Manuals include detailed information for providers to understand health plan operations and requirements. However, Humana's Provider Manual did not include information about reassignment of a member to a different PCP.

### *Preventive Health and Clinical Practice Guidelines*

*42 CFR § 438.236, 42 CFR § 457.1233(a)*

Processes are in place for reviewing and adopting preventive health guidelines (PHGs) and clinical practice guidelines (CPGs). Review and adoption are functions of ATC's Quality Improvement Committee (QIC), Humana's Corporate Quality Improvement

Committee (CQIC), and the Quality Assessment and Performance Improvement Committee (QAPIC) for Select Health. The adopted guidelines are relevant to the member populations and originate from recognized sources. The health plans educate providers about the guidelines through general provider education sessions, plan websites, and newsletters.

Each of the MCOs also educates providers about medical record documentation and maintenance requirements. Provider compliance with the medical record documentation standards is evaluated through routine medical record audits. Audit results are used for quality improvement activities.

The 2022 EQR confirmed Select Health adequately addressed deficiencies noted during the 2021 EQR. See *Table 21: 2021 Practitioner Medical Records QIP Items – Select Health* for the identified issue and Select Health's response.

**Table 21: 2021 Practitioner Medical Records QIP Items – Select Health**

| Standard | EQR Comments |
|---|---|
| **II G. Practitioner Medical Records** | |
| 2. Standards for acceptable documentation in member medical records are consistent with contract requirements. | Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, do not include all required elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*.<br>The Provider Manual, pages 19-21, includes a comprehensive list of medical record documentation elements and informs providers that Select Health PCP sites are monitored annually for compliance with the standards listed.<br>Quality Improvement Plan: Revise Policy QI 154.009, Medical Record Review, and Attachment A, Medical Record Review Evaluation Form, to include all medical record documentation elements required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O).* |
| **Select Health Response:** Policy QI 154.009 was revised on 01/20/2022 at the Policy and Procedure Meeting. The revisions included the elements required under Section 15.7(o) of the SCDHHS Policy and Procedure Guide for Managed Care Organizations. Please see the attached red line and final version of policy QI 154.009. | |

## *Continuity of Care*

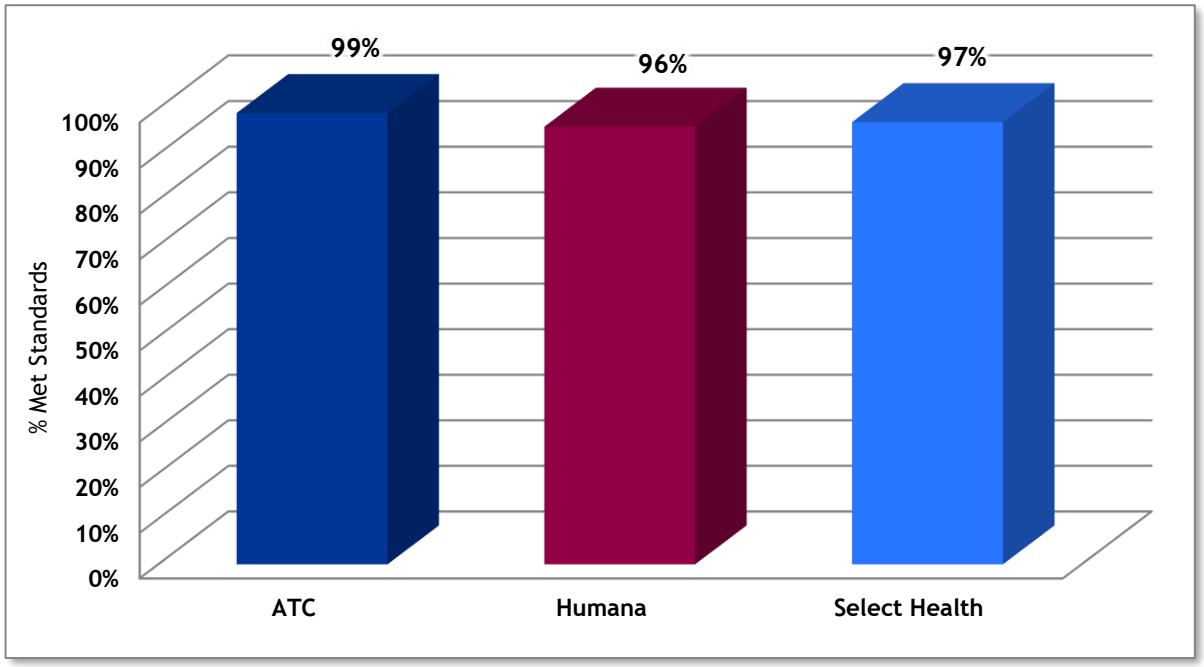
*42 CFR § 438.208, 42 CFR § 457.1230(c)*

Health plan policies define processes for monitoring and evaluating continuity and coordination of care. This is accomplished through activities such as medical record audits, monitoring HEDIS measures, member and provider satisfaction surveys, internal

data (UM, pharmacy, appeal, grievance). Results of this monitoring are used for quality improvement activities.

The percentages of "Met" scores achieved by each plan for the Provider Services section of the review are illustrated in *Figure 7: Provider Services*.

**Figure 7: Provider Services**




An overview of the scores for the Provider Services section is illustrated in *Table 22: Provider Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 22: Provider Services Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Credentialing and Recredentialing<br>*42 CFR § 438.214, 42 CFR § 457.1233(a)* | | | | |
| 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 | Met | Met ↑ | Met | **Strengths:**<br>▶ Written program descriptions and policies provide detailed processes and requirements for initial and ongoing credentialing activities.<br>▶ The MCOs have established committees that use a peer review process to make recommendations for credentialing decisions. The committees meet at defined, routine intervals and are chaired by the health plans' Medical Director or Chief Medical Officer.<br>▶ Credentialing and recredentialing files for individual practitioners and organizational providers were fully compliant with all requirements.<br>▶ The health plans monitor for, and take action to address, provider quality of care/service issues and sanctions that would prohibit providers from receiving Federal funds.<br><br>**Weaknesses:**<br>▶ ATC was noncompliant with its Credentialing Committee policy's requirement that members of the Credentialing Committee must be in-network providers, and documentation of committee member attendance was unclear. |
| 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 | Partially Met ↓ | Met | Met | |
| The credentialing process includes all elements required by the contract and by the MCO's internal policies. | Met | Met ↑ | Met | |
| Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members | Met | Met | Met | |
| Valid DEA certificate and/or CDS certificate | Met | Met | Met | |
| Professional education and training, or board certification if claimed by the applicant | Met | Met | Met | |
| Work history | Met | Met | Met | |
| Malpractice claims history | Met | Met | Met | |
| Formal application with attestation statement | Met | Met | Met | |
| Query of the National Practitioner Data Bank (NPDB) | Met | Met | Met | |
| Not debarred, suspended, or excluded from Federal procurement activities:<br>Query of System for Award Management (SAM) | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) | Met | Met | Met | ▶ Humana's Credentials Committee lacks a variety of specialists such as internal medicine, general surgery, neurology, etc.<br><br>**Recommendations:**<br>• Ensure the composition of credentialing committees is compliant with all contractual and/or policy requirements.<br>• Ensure documentation of attendance for voting members of credentialing committees is clear. |
| Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list | Met | Met ↑ | Met | |
| Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE) | Met | Met | Met | |
| Query of Social Security Administration's Death Master File (SSDMF) | Met | Met ↑ | Met | |
| Query of the National Plan and Provider Enumeration System (NPPES) | Met | Met | Met | |
| In good standing at the hospital designated by the provider as the primary admitting facility | Met | Met | Met | |
| Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures | Met | Met | Met | |
| Receipt of all elements prior to the credentialing decision, with no element older than 180 days | Met | Met | Met | |
| The recredentialing process includes all elements required by the contract and by the MCO's internal policies | Met | Met ↑ | Met | |
| Recredentialing conducted at least every 36 months | Met | Met | Met | |
| Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members | Met | Met | Met | |
| Valid DEA certificate and/or CDS certificate | Met | Met | Met | |
| Board certification if claimed by the applicant | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | = *Quality*<br>= *Timeliness*<br>= *Access to Care* |
|---|---|---|---|---|
| Malpractice claims since the previous credentialing event | Met | Met | Met | |
| Practitioner attestation statement | Met | Met | Met | |
| Requery the National Practitioner Data Bank (NPDB) | Met | Met | Met | |
| Requery of System for Award Management (SAM) | Met | Met | Met | |
| Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline) | Met | Met | Met | |
| Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list | Met | Met ↑ | Met | |
| Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE) | Met | Met | Met | |
| Query of the Social Security Administration's Death Master File (SSDMF) | Met | Met ↑ | Met | |
| Query of the National Plan and Provider Enumeration System (NPPES) | Met | Met | Met | |
| In good standing at the hospitals designated by the provider as the primary admitting facility | Met | Met | Met | |
| Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures | Met | Met | Met | |
| Review of practitioner profiling activities | Met | Met | Met | |
| 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 | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities | Met | Met ↑ | Met | |
| Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds | Met | Met ↑ | Met | |
| Adequacy of the Provider Network<br>*42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 438.10(h), 42 CFR § 457.1230(a) (b), 42 CFR § 457.1230(b)* | | | | |
| The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.<br><br>Members have a primary care physician located within a 30-mile radius of their residence | Met | Met | Met | **Strengths:**<br>▶ The health plans monitor the adequacy of their networks to ensure appropriate geographic access to PCPs, specialists, hospitals, etc., and contract with all required Status 1 provider types.<br>▶ Activities are conducted to evaluate and ensure the provider networks can meet the cultural, ethnic, racial, and linguistic needs of members.<br>▶ The MCOs ensure providers receive education and resources about Cultural Competency.<br>▶ For the Telephonic Provider Access Studies conducted by CCME, overall access to providers improved for two plans and was sustained at the same rate for one plan.<br><br>**Weaknesses:**<br>▶ Select Health's Availability of Practitioners and Behavioral Health Provider Availability policies do not address the requirement from the *SCDHHS* |
| 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 | Met | Met | Partially Met ↓ | |
| The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually | Met ↑ | Met | Met | |
| Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand | Met | Met | Met | *Contract, Section 6.2.3.1.4* that MCOs must provide a choice of at least two required contracted specialists and/or subspecialists who are accepting new patients within the geographic area.<br>▶ Humana's PDF versions of the Provider Directories included contradictory information about how members can determine providers that are not accepting new patients and did not indicate any providers who are not accepting new patients, as required by the *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR 438.10 (h) (1) (vi)*.<br>▶ Policies addressing appointment access and processes for monitoring provider compliance with those standards did not requirements did not define the frequency for conducting the mystery shopper call studies (Humana) and did not include all contractual appointment access requirements (Select Health).<br><br>**Recommendations:**<br>• Ensure network adequacy policies address all contractual requirements for provider network adequacy.<br>• Ensure Provider Directories include an indicator of any providers who are not accepting new patients.<br>• Ensure policies addressing appointment access standards and monitoring processes provide full detail about processes and address all |
| The MCO maintains a provider directory that includes all requirements outlined in the contract | Met | Partially Met ↓ | Met | |
| 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 | Met | Met | Partially Met | |
| The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results | Met ↑ | Met | Met ↑ | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| | | | | contractually required appointment access standards. |
| Provider Education<br>*42 CFR § 438.414, 42 CFR § 457.1260* | | | | |
| The MCO formulates and acts within policies and procedures related to initial education of providers | Met | Not Met ↓ | Met | **Strength:**<br>▶ The MCO's have established processes for conducting initial and ongoing provider education through various forums.<br><br>**Weaknesses:**<br>▶ Humana's Provider Orientation and Annual Training policy (SC.NNO.007) was not specific to SC and Humana's Provider Manual did not address reassignment of a member to a different PCP.<br><br>**Recommendations:**<br>• Ensure policies reflect processes and requirements specific to SC operations regarding initial and ongoing provider education.<br>• Ensure the Provider Manual includes all information providers need to understand requirements. |
| Initial provider education includes:<br>MCO structure and health care programs | Met | Met | Met | |
| Billing and reimbursement practices | Met | Met | Met | |
| Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS | Met | Met ↑ | Met | |
| Procedure for referral to a specialist | Met | Met | Met | |
| Accessibility standards, including 24/7 access | Met | Met | Met | |
| Recommended standards of care | Met | Met | Met | |
| Medical record handling, availability, retention and confidentiality | Met | Met | Met | |
| Provider and member grievance and appeal procedures | Met | Met | Met | |
| Pharmacy policies and procedures necessary for making informed prescription choices | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Reassignment of a member to another PCP | Met | Partially Met ↓ | Met | |
| Medical record documentation requirement. | Met | Met | Met | |
| The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures | Met | Met | Met | |
| Primary and Secondary Preventive Health Guidelines<br>*42 CFR § 438.236, 42 CFR § 457.1233(a)* | | | | |
| The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated | Met | Met | Met | **Strengths:**<br>▶ The MCOs have appropriate processes in place for adoption and ongoing review of preventive health guidelines.<br>▶ The adopted guidelines address appropriate topics that are relevant to the member populations. |
| The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers | Met | Met | Met | |
| The preventive health guidelines include, at a minimum, the following if relevant to member demographics:<br>Well child care at specified intervals, including EPSDTs at State-mandated intervals | Met | Met | Met | |
| Recommended childhood immunizations | Met | Met | Met | |
| Pregnancy care | Met | Met | Met | |
| Adult screening recommendations at specified intervals | Met | Met | Met | |
| Elderly screening recommendations at specified intervals | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Recommendations specific to member high-risk groups | Met | Met | Met | |
| Behavioral Health Services | Met | Met | Met | |
| Clinical Practice Guidelines for Disease and Chronic Illness Management<br>*42 CFR § 438.236, 42 CFR § 457.1233(a)* | | | | |
| 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 | Met | Met | Met | **Strengths:**<br>▶ The MCOs have appropriate processes in place for adoption and ongoing review of clinical practice guidelines.<br>▶ The adopted guidelines address appropriate topics that are relevant to the member populations. |
| 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 | Met | Met | Met | |
| Continuity of Care<br>*42 CFR § 438.208, 42 CFR § 457.1230(c)* | | | | |
| The MCO monitors continuity and coordination of care between the PCPs and other providers | Met | Met | Met | **Strengths:**<br>▶ The MCO's have policies and established processes for monitoring continuity and coordination of care between PCPs and other providers.<br>▶ Activities conducted to monitor coordination and continuity of care include monitoring HEDIS measures, CAHPS data, member satisfaction survey results, conducting medical record reviews, monitoring disease/case management data, etc. |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Practitioner Medical Records | | | | |
| The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians | Met | Met | Met | **Strengths:**<br>▶ The health plans have policies defining standards for provider medical record documentation and they educate providers about the standards in a variety of ways.<br>▶ Routine medical record audits are conducted to assess provider compliance with the medical record documentation standards. |
| Standards for acceptable documentation in member medical records are consistent with contract requirements | Met | Met | Met ↑ | |
| The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers | Met | Met | Met | |
| 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 | Met | Met | Met | |

## 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*

The review of Member Services encompassed member rights and responsibilities, member education, processes for enrollment and disenrollment, member satisfaction surveys, grievance processes and requirements, and a review of a sample of grievance files.

New members are informed of their rights and responsibilities via new member welcome packets, Member Handbooks, and health plan websites. Policies and onsite discussion confirmed that new member materials are provided within 14 calendar days after receipt of enrollment information. The packets include information such as an introduction letter, ID card, Member Handbook, and instructions for accessing the Provider Directory.

The Member Handbooks and new member welcome packets serve as an educational resource for members to understand each health plan's operations, processes, services, covered benefits, and contact information. Humana's Member Handbook did not address coverage for non-hospital based rehabilitative therapies for children. CCME recommended Humana revise the Member Handbook to address coverage for this benefit.

Members receive notice of any significant changes in benefits or the provider network at least 30 calendar days before the intended effective date of the change. Members are also notified at least annually of their right to request a copy of the Member Handbook and the Provider Directory.

The steps for requesting assistance with interpretation services or materials in languages other than English are clearly outlined in printed materials and manuals. Members also have access to a nurse advice line 24 hours a day, seven days a week. Medical advice for children and adults, health information, assistance in determining where to go for care, answers to personal health questions, and information about pregnancy are examples of topics available to members by calling the nurse advice line.

### *Member Enrollment and Disenrollment*

*42 CFR § 438.56*

Policies detail processes for member enrollment and disenrollment. The enrollment process for new members begins with the member selecting a primary care physician (PCP). If the member does not select a PCP, one will be auto assigned based on the member's location. Policies also define processes for member-initiated disenrollment requests and involuntary disenrollment initiated by the health plans or by SCDHHS. Humana requires members to file a grievance prior to requesting disenrollment. The *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5,* includes no requirement that members must file a grievance with the health plan to request disenrollment.

## *Member Satisfaction Survey Validation*

Member satisfaction survey validation for each health plan was performed based on the CMS Survey Validation Protocol. A certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor conducted a formal annual assessment of member satisfaction that met all the requirements of the CMS Survey Validation Protocol. *Table 23: Summary of Member Survey Results* provides an overview of each health plan's survey results. This was the first year the CAHPS survey was administered for Humana. The minimum number of completed surveys was less than the NCQA target of 411 surveys for the three populations surveyed for each health plan.

**Table 23: Summary of Member Survey Results**

| Plan | CAHPS Survey Version | Summary Survey Results |
|---|---|---|
| ATC | Adult | For the Adult CAHPS, Personal Doctor Spent Enough Time with the Patient improved significantly. The adult response rate was 10.3% (228 out of 2228) which is a decline from last year's rate of 12.1%. |
| | Child | The Child CAHPS results found improvements in the Getting Need Care, Getting Care Quickly, and the Rating of the Health Plan were all above the benchmark. The child survey response rate was 7.8% (198 out of 2558), which is a decline from last year's rate of 9.4%. |
| | Child with Chronic Conditions (CCC) | The results of the Child with Chronic Conditions (CCC) survey found ATC showed improvements in the Getting Needed Care, Getting Care Quickly, and the Rating of Health Care measures. The CCC response rate was 7.2% (118 out of 1650) which is a decline from last year's rate of 9.6%. |
| Humana | Adult | The response rates were 5.1% (10 of 198 surveys completed) for the adult survey. Adult rates were above the 90th (Quality Compass) percentile for Getting Needed Care, Getting Care Quickly, Coordination of Care, and Advised to Quit Smoking. |
| | Child | The response rate was 7.9% (9 of 114) for the child survey. The child rates were above the 90th percentile for Rating of Specialist and Coordination of Care. |
| | Child with Chronic Conditions (CCC) | The response rate was 5.4% (4 of 74) for the children with chronic conditions (CCC) survey. The CCC rates were also above the 90th percentile for Getting Care Quickly. |
| Select Health | Adult | The adult response rate was 13.4% (226 out of 1692) which is a decline from the previous year's response rate of 16.5%. Multiple CAHPS Measures rates scored higher in 2022. Coordination of Care experienced the largest improvement, improving by 5.1 percentage points. Among the Adult population, several measures declined compared to last year. The biggest decreases were in the Rating of Health Plan and Getting Care Quickly which both declined more than five percentage points. |

| Plan | CAHPS Survey Version | Summary Survey Results |
|---|---|---|
| | Child | Child response rate was 13.7% (306 out of 2234) which is a decline from the previous year's response rate of 16.6%. All Child CAHPS measures met the plan's goal of the 75th percentile. Getting Needed Care experienced the largest improvement increasing by 2.5 percentage points. |
| | Child with Chronic Conditions (CCC) | The CCC response rate was 12.8% (210 out of 1640) which is a decline from the previous year's rate of 17.2%. Access to Specialized Services experienced the largest improvement, increasing by 6.2 percentage points. Among the Child CCC population, Rating of Specialist declined by 15.5 percentage points. |

## *Grievances*

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

Processes and requirements for handling grievances were found in the health plan's policies, Member Handbooks, Provider Manuals, and on plan websites. Definitions and timeliness requirements for grievance resolution were detailed in the policies. However, for Humana, it was noted that the definition of a grievance was incorrect in their policy, in the Member Handbook, and on the website. Grievance logs are maintained for each health plan, and data is tracked, trended, and reported to quality committees to identify areas of potential quality Improvement opportunities. CCME reviewed a sample of grievance files for each health plan. Overall, the files demonstrated that grievances were processed timely and appropriate notifications of resolution were provided.

During the 2022 EQR of Humana, it was found that Humana was not processing grievances timely. This was addressed with a Quality Improvement Plan submitted by Humana and the current EQR found the deficiency had been corrected. The table that follows provides an overview of this deficiency and Humana's response.

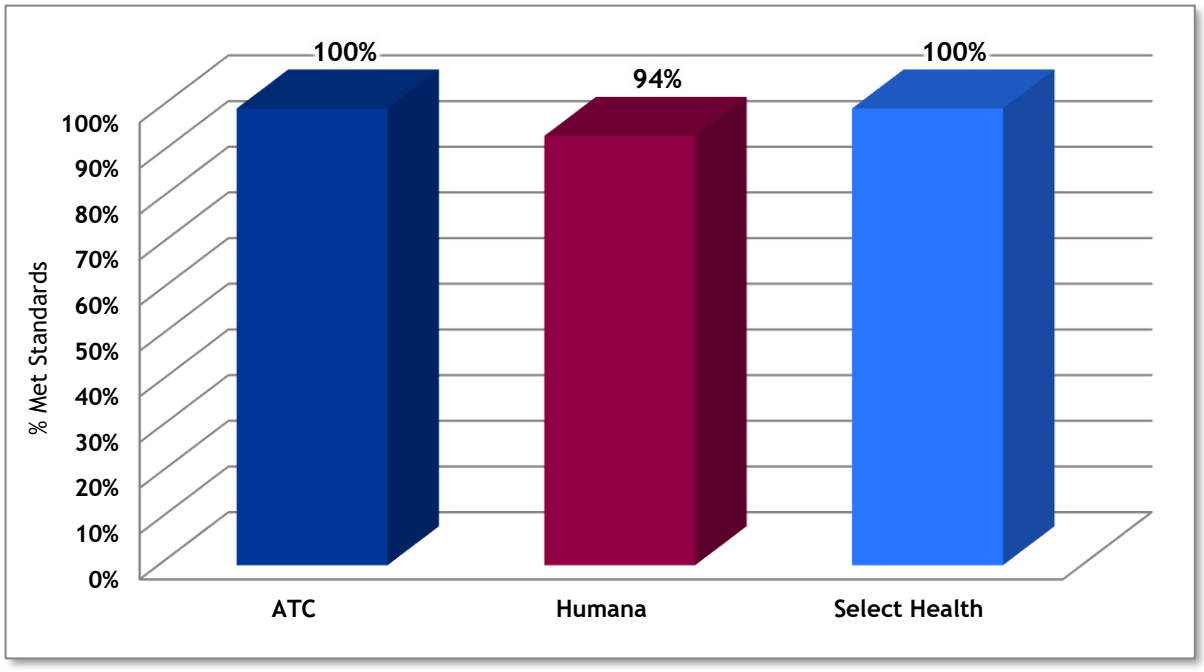
**Table 24: Humana 2022 EQR Grievances Deficiencies and QIP Responses**

| Standard | EQR Comments |
|---|---|
| **III F. Grievances** | |
| 2. The MCO applies grievance policies and procedures as formulated. | Humana submitted seven grievance files for review.<br>Two of the seven files did not meet Humana's timeliness policy for sending an acknowledgement letter.<br>One file was noted as still in progress. This grievance was received on November 16, 2021 and should have been resolved by February 14, 2022. There was no information regarding a request for an extension.<br>In one file, the member complained that she was unable to locate a PCP in her area and requested a list of PCPs. Humana attempted to reach the member by phone without success. Humana sent the |

| Standard | EQR Comments |
|---|---|
| | member resolution letter 10 days after receipt without providing the member with a list of PCPs.<br>*Quality Improvement Plan: Review processes and timeliness standards for grievances and implement steps for performance improvements.* |
| **Humana's Response:** Humana has metrics for all the G&A timeframes that are used to monitor timeliness, and the results are monitored daily, weekly, and reported out monthly. The results are reported to the Operational Risk Management team for tracking in a dashboard format and shared at the enterprise level. When a metric is missed, the G&A team is responsible for providing the mitigation / corrective action plan to the Operational Risk Management team, along with the results. The G&A team also reports the acknowledgement and resolution letter timeliness metrics to the Quality Improvement Committee on a quarterly basis, along with action plans to improve performance when needed. | |

*Figure 8: Member Services* provides an overview of the plans' performance in the Member Services section.

**Figure 8: Member Services**




A comparison of the plans' scores for the standards in the Member Services section is illustrated in *Table 25: Member Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 25: Member Services Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Member Rights and Responsibilities<br>*42 CFR § 438.100, 42 CFR § 457.1220* | | | | |
| The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities | Met | Met | Met | **Strength:**<br>▶ Member Rights and Responsibilities are clearly identified by each MCO in policies, in their Member welcome packet, the Member Handbook, the Provider Manual, and on the plan websites. |
| All Member rights included | Met | Met | Met | |
| Member MCO Program Education<br>*42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)* | | | | |
| Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information | Met | Met | Met | |
| Members are notified at least once per year of their right to request a Member Handbook or Provider Directory | Met | Met | Met | |
| Members are informed in writing of changes in benefits and changes to the provider network | Met | Met | Met | |
| Member program education materials are written in a clear and understandable manner and meet contractual requirements | Met | Met | Met | |
| The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Member Enrollment and Disenrollment<br>*42 CFR § 438.56's* | | | | |
| The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed | Met | Met | Met | **Weakness:**<br>▶ Humana requires the member to file a grievance in order to request disenrollment.<br><br>**Recommendation:**<br>• Processes and polices should be revised and remove the requirement that a member must file a grievance in order to request disenrollment. |
| MCO-initiated member disenrollment requests are compliant with contractual requirements | Met | Not Met↓ | Met | |
| Preventive Health and Chronic Disease Management Education | | | | |
| The MCO informs members of available preventive health and disease management services and encourages members to utilize these services | Met | Met | Met | **Strength:**<br>▶ Members are informed of available preventive health and disease management services, available resources, and are encouraged to utilize services as needed. |
| The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits | Met | Met | Met | |
| The MCO provides education to members regarding health risk factors and wellness promotion | Met | Met | Met | |
| 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 | Met | Met | Met | |
| Member Satisfaction Survey | | | | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to | Met | Met | Met | |
| Statistically sound methodology, including probability sampling to ensure it is representative of the total membership | Met | Met | Met | |
| The availability and accessibility of health care practitioners and services | Met | Met | Met | |
| The quality of health care received from MCO providers | Met | Met | Met | |
| The scope of benefits and services | Met | Met | Met | |
| Claim processing procedures | Met | Met | Met | |
| Adverse MCO claim decisions | Met | Met | Met | |
| The MCO analyzes data obtained from the member satisfaction survey to identify quality issues | Met | Met | Met | |
| The MCO implements significant measures to address quality issues identified through the member satisfaction survey | Met | Met | Met | |
| The MCO reports the results of the member satisfaction survey to providers | Met | Met | Met | |
| 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 | Met | Met | Met | |
| Grievances<br>*42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| 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 | Met | Met | Met | **Strength:**<br>▶ The grievance files reviewed for this EQRs met timeliness standards for acknowledgment and resolution letters.<br><br>**Weakness:**<br>▶ Humana's definitions of grievance terminology used outdated language and were incomplete.<br><br>**Recommendation:**<br>• The definition for a grievance should match the definition used in the SCDHHS Contract and in Federal Regulations. |
| The definition of a grievance and who may file a grievance | Met | Partially Met ↓ | Met | |
| Procedures for filing and handling a grievance | Met | Met | Met | |
| Timeliness guidelines for resolution of a grievance | Met | Met | Met | |
| Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee | Met | Met | Met | |
| Maintenance and retention of a grievance log and grievance records for the period specified in the contract | Met | Met | Met | |
| The MCO applies grievance policies and procedures as formulated | Met | Met ↑ | Met | |
| Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee | Met | Met | Met | |
| Grievances are managed in accordance with the MCO confidentiality policies and procedures | Met | Met | Met | |

## D. Quality Improvement

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

MCOs are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the health plans in SC included review of the programs' structures, work plans, program evaluations, performance measure validation, and performance improvement project validation.

Each MCO provided their current QI Program Descriptions. These program descriptions provided an overview of the QI Programs that have been established to improve the quality of care delivered to their members. The QI Program Descriptions for ATC and Select Health included the program's structure, goals, scope, and methodology. Humana's program description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships). Humana addressed this onsite and indicated there were currently five staff assigned to the QI program as well as the Medical Director's involvement. The Organizational Chart for the Quality Department was provided after the onsite.

Annually, the MCOs develop a work plan to help manage workflow, assign tasks, and track various components of the QI Program. The work plans included the scope, activity description and objectives, responsible party, timeline, and the status for each activity.

Each health plan has established a committee responsible for the oversight of their QI Programs. These committees evaluated the results of the QI activities and made recommendations as needed. Minutes were maintained for each meeting and copies of the meeting minutes were provided with the desk materials. Participating practitioners from each MCO serve as voting members of the QI committees and provide clinical review and feedback to the committee.

The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QI Committee. However, Humana's committee minutes for meetings held in 2022 did not include any participating network practitioners. The minutes for the meeting held in January 2023 documented one network practitioner and one physician consultant, not participating in Humana's network, had been added. This was an issue identified during the 2022 EQR and not corrected. The table that follows provides an overview of the previous deficiency and Humana's response.

**Table 26: 2022 Quality Improvement Program Deficiency - Humana**

| Standard | EQR Comments |
|---|---|
| **IV A. The Quality Improvement (QI) Program** | |
| 2. The composition of the QI Committee reflects the membership required by the contract. | Humana's Medical Director serves as chair for the QAC. Members of the committee include senior staff department leads, directors, and managers. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. However, the membership list and committee minutes for this committee did not include any participating network practitioners. Humana indicated recruitment efforts are underway to recruit providers.<br>*Quality Improvement Plan: Recruit a variety of participating network providers as members of the Quality Assurance Committee.* |
| **Humana's Response:** Humana is currently recruiting for In-Network providers to join the Quality Assurance Committee as voting members. The Quality Director participates with Provider Contracting and Provider Engagement meetings. The Chief Medical Officer is actively engaged to help recruit providers. As a result, we have three providers that are showing interest in joining QAC. | |

The health plans require all network providers to comply with the requirements outlined in the provider agreements, including participation with quality assessment and improvement activities. A sample provider agreement was provided that outlined these requirements. Network providers are also encouraged to participate through committees that play an active role in the direction and specific initiatives for the QI Programs.

Results of provider performance are shared through various quality reports, dashboards, provider report cards and gaps in care reports.

Each MCO evaluates the overall effectiveness of the QI Program and reports the evaluation to the Board of Directors and to their Quality Improvement Committees. Each plan provided copies of the Annual Evaluations for review.

Humana provided the 2021 – 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation for review. The QI Program Evaluation included the outcomes of some of the activities completed during 2021 and 2022. A barrier analysis and recommendations for 2023 to overcome those barriers were also included. This evaluation lacked results and analysis for the following activities:

- Timely Access/PCP Wait Times
- Network Adequacy (time and distances)
- The Utilization Management Overview Data (Over and Underutilization)
- Delegation Oversight monitoring

Also, the goal for measuring the credentialing and recredentialing activities appeared to be incorrect. The goal listed in the background information for completing the credentialing process as 30 days. The results table listed the goal as 90 days and the goal noted in the 2022 QI work plan was 60 days. The graph on page 20 of the QI Program Evaluation only included the results of the recredentialing activities. These deficiencies were discussed during the onsite. Staff explained the QI Program Evaluation was created for accreditation purposes and did not contain 12 months of data.

### *Performance Measure Validation*

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

Health plans are required to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the PMs reported, CCME uses the *CMS Protocol, Validation of Performance Measures*. This validation protocol balances the subjective and objective parts of the review, supports a review that is fair to the plans, and provides the State with information about how each plan is operating.

All plans are using a HEDIS® certified vendor or software to collect and calculate the measures, and all were found to be "Fully Compliant." Plan rates for the most recent review year are reported in *Table 27: HEDIS® Performance Measure Data for HEDIS 2020*. Due to low enrollment for Humana, during this time period several rates were not reported due to a zero denominator.

Rates highlighted in green indicate a substantial improvement of more than 10 percent year over year. Rates highlighted in red indicate a substantial decrease of more than 10 percent. Since this was the first year Humana reported HEDIS measures, no comparisons were made for Humana.

**Table 27: HEDIS® Performance Measure Data for HEDIS MY2021**

| Measure/Data Element | ATC Measure Year 2021 | Humana Measure Year 2021 | Select Health Measure Year 2021 |
|---|---|---|---|
| **Effectiveness of Care: Prevention and Screening** | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | | | |
| *BMI Percentile* | 65.94% | 85.71%* | 74.47% |
| *Counseling for Nutrition* | 59.12% | 71.43%* | 70.21% |
| *Counseling for Physical Activity* | 53.77% | 71.43%* | 69.41% |
| Childhood Immunization Status (cis) | | | |
| *DTaP* | 64.23% | NR | 72.02% |

| Measure/Data Element | ATC Measure Year 2021 | Humana Measure Year 2021 | Select Health Measure Year 2021 |
|---|---|---|---|
| *IPV* | 79.56% | NR | 86.13% |
| *MMR* | 81.51% | NR | 84.91% |
| *HiB* | 73.97% | NR | 82.24% |
| *Hepatitis B* | 77.13% | NR | 85.89% |
| *VZV* | 81.02% | NR | 84.43% |
| *Pneumococcal Conjugate* | 66.91% | NR | 72.75% |
| *Hepatitis A* | 78.35% | NR | 84.67% |
| *Rotavirus* | 64.48% | NR | 70.8% |
| *Influenza* | 37.71% | NR | 36.25% |
| *Combination #3* | 57.18% | NR | 65.69% |
| *Combination #7* | 50.12% | NR | 56.45% |
| *Combination #10* | 27.01% | NR | 27.25% |
| Immunizations for Adolescents (ima) | | | |
| *Meningococcal* | 72.26% | NR | 77.37% |
| *Tdap/Td* | 81.75% | NR | 85.64% |
| *Combination #1* | 72.02% | NR | 40.39% |
| *Combination #2* | 33.82% | NR | 76.64% |
| *Human Papillomavirus Vaccine for Female Adolescents* | 34.79% | NR | 39.17% |
| Lead Screening in Children (lsc) | 63.79% | NR | 67.54% |
| Breast Cancer Screening (bcs) | 54.62% | 33.33%* | 56.02% |
| Cervical Cancer Screening (ccs) | 61.8% | 25%* | 60.65% |
| Chlamydia Screening in Women (chl) | | | |
| *Total* | 61.77% | 0%* | 58.8% |
| **Effectiveness of Care: Respiratory Conditions** | | | |
| Appropriate Testing for Children with Pharyngitis (cwp) | | | |
| *Total* | 74.17% | NR | 76.3% |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr) | 22.49% | NR | 29.64% |
| Pharmacotherapy Management of COPD Exacerbation (pce) | | | |
| *Systemic Corticosteroid* | 68.83% | 100%* | 62.64% |
| *Bronchodilator* | 80.97% | 100%* | 81.51% |
| Asthma Medication Ratio (amr) | | | |
| *Total* | 68.39% | 100%* | 74.21% |
| **Effectiveness of Care: Cardiovascular Conditions** | | | |
| Controlling High Blood Pressure (cbp) | 42.82% | 0%* | 59.51% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | 79.07% | NR | 68.12% |

| Measure/Data Element | ATC Measure Year 2021 | Humana Measure Year 2021 | Select Health Measure Year 2021 |
|---|---|---|---|
| Statin Therapy for Patients With Cardiovascular Disease (spc) | | | |
| *Received Statin Therapy - Total* | 79.5% | 100%* | 80.52% |
| *Statin Adherence 80% - Total* | 59.11% | 100%* | 59.48% |
| Cardiac Rehabilitation (CRE) | | | |
| *Cardiac Rehabilitation - Initiation (Total)* | 2.05% | NR | 2.03% |
| *Cardiac Rehabilitation - Engagement1 (Total)* | 2.46% | NR | 2.37% |
| *Cardiac Rehabilitation - Engagement2 (Total)* | 0.82% | NR | 2.03% |
| *Cardiac Rehabilitation - Achievement (Total)* | 0.00% | NR | 0.68% |
| **Effectiveness of Care: Diabetes** | | | |
| Comprehensive Diabetes Care (cdc) | | | |
| *Hemoglobin A1c (HbA1c) Testing* | 84.91% | 100%* | 85.64% |
| *HbA1c Poor Control (>9.0%)* | 37.23% | 0%* | 48.66% |
| *HbA1c Control (<8.0%)* | 52.8% | 100%* | 42.82% |
| *Eye Exam (Retinal) Performed* | 48.42% | 0%* | 47.45% |
| *Blood Pressure Control (<140/90 mm Hg)* | 50.36% | 0%* | 63.02% |
| Kidney Health Evaluation for Patients With Diabetes (ked) | | | |
| *Kidney Health Evaluation for Patients With Diabetes (Total)* | 23.56% | NR | 24.39% |
| Statin Therapy for Patients With Diabetes (spd) | | | |
| *Received Statin Therapy* | 65.82% | NR | 62.07% |
| *Statin Adherence 80%* | 59.5% | NR | 54.18% |
| **Effectiveness of Care: Behavioral Health** | | | |
| Antidepressant Medication Management (amm) | | | |
| *Effective Acute Phase Treatment* | 51.59% | NR | 48.03% |
| *Effective Continuation Phase Treatment* | 35.89% | NR | 31.16% |
| Follow-Up Care for Children Prescribed ADHD Medication (add) | | | |
| *Initiation Phase* | 37.55% | NR | 36.12% |
| *Continuation and Maintenance (C&M) Phase* | 53.78% | NR | 51.53% |
| Follow-Up After Hospitalization for Mental Illness (fuh) | | | |
| *Total - 30-Day Follow-Up* | 59.23% | 80%* | 67.1% |
| *Total - 7-Day Follow-Up* | 37.59% | 60%* | 42.75% |
| Follow-Up After Emergency Department Visit for Mental Illness (fum) | | | |
| *Total - 30-Day Follow-Up* | 51.2% | 75%* | 64.04% |
| *Total - 7-Day Follow-Up* | 39.45% | 25%* | 47.62% |
| Follow-Up After High-Intensity Care for Substance Use Disorder (fui) | | | |

| Measure/Data Element | ATC Measure Year 2021 | Humana Measure Year 2021 | Select Health Measure Year 2021 |
|---|---|---|---|
| *Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)* | 31.23% | NR | 39.73% |
| *Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)* | 17.03%% | NR | 25% |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) | | | |
| *Total - 30-Day Follow-Up* | 12.33% | 0%* | 15.68% |
| *Total - 7-Day Follow-Up* | 8.17% | 0%* | 11.35% |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd) | 76.8% | 100%* | 77.22% |
| Diabetes Monitoring for People With Diabetes and Schizophrenia (smd) | 68.39% | NR | 61.17% |
| Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc) | NA* | NR | 70.83% |
| Pharmacotherapy for Opioid Use Disorder (pod) | | | |
| *Total* | 41.03% | NR | 35.11% |
| Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa) | 60.64% | NR | 62.53% |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) | | | |
| *Blood glucose testing - Total* | 49.36% | NR | 56.84% |
| *Cholesterol Testing - Total* | 33.01% | NR | 35.98% |
| *Blood glucose and Cholesterol Testing - Total* | 31.09% | NR | 34.37% |
| **Effectiveness of Care: Overuse/Appropriateness** | | | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs) | 1.34% | NR | 0.67% |
| Appropriate Treatment for Children With URI (uri) | | | |
| *Total* | 87.8% | NR | 87.97% |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) | | | |
| *Total* | 54.37% | NR | 47.66% |
| Use of Imaging Studies for Low Back Pain (lbp) | 69.95% | NR | 72.83% |
| Use of Opioids at High Dosage (hdo) | 2.18% | NR | 4.23% |
| Use of Opioids From Multiple Providers (uop) | | | |
| *Multiple Prescribers* | 15.8% | NR | 18.42% |
| *Multiple Pharmacies* | 1.08% | NR | 2.57% |
| *Multiple Prescribers and Multiple Pharmacies* | 0.62% | NR | 1.65% |
| Risk of Continued Opioid Use (cou) | | | |
| *Total - >=15 Days covered* | 3.72% | NR | 1.99% |
| *Total - >=31 Days covered* | 2.42% | NR | 0.98% |
| **Access/Availability of Care** | | | |
| Adults' Access to Preventive/Ambulatory Health Services (aap) | | | |

| Measure/Data Element | ATC Measure Year 2021 | Humana Measure Year 2021 | Select Health Measure Year 2021 |
|---|---|---|---|
| *Total* | 78.18% | 91.67%* | 79.1% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: Total* | 41.84% | NR | 37.73% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: Total* | 6.09% | NR | 7.39% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: Total* | 58.62% | NR | 63.13% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 33.52% | NR | 37.57% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: Total* | 40.57% | 100%* | 35.8% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: Total* | 7.26% | 0%* | 8.63% |
| *Initiation of AOD Treatment: Total* | 43.41% | 100%* | 40% |
| *Engagement of AOD Treatment: Total* | 10.99% | 0%* | 12.46% |
| Prenatal and Postpartum Care (ppc) | | | |
| *Timeliness of Prenatal Care* | 85.64% | 100%* | 86.9% |
| *Postpartum Care* | 69.83% | 0%* | 77.96% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) | | | |
| *Total* | 61.2% | NR | 62.57% |
| **Utilization** | | | |
| Well-Child Visits in the First 30 Months of Life (W30) | | | |
| *Well-Child Visits in the First 30 Months of Life (First 15 Months)* | 55.64% | NR | 51.38% |
| *Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)* | 68.65% | NR | 73.28% |
| Child and Adolescent Well-Care Visits (WCV) | | | |
| *Child and Adolescent Well-Care Visits (Total)* | 45.12% | 50%* | 49.89% |

*Note: NR = Not Reported; NA= Not Applicable due to missing data or small denominator; * denominator less than 30*

ATC demonstrated a substantial increase in the Persistence of Beta-Blocker Treatment After a Heart Attack measure. There were no measures that demonstrated a substantial increase for Select Health.

Three measures showed a decline in rate for Select Health. Those included the Pharmacotherapy Management of COPD Exacerbation, Systemic Corticosteroid; Persistence of Beta-Blocker Treatment After a Heart Attack; and the Pharmacotherapy for Opioid Use Disorder, Total. There were no measures that demonstrated a substantial decrease for ATC.

## *Performance Improvement Project Validation*

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

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

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

Six projects were validated for the three plans. Results of the validation, the project status, and interventions for each project are displayed in the tables that follow.

ATC submitted two PIPs for validation. Topics for the PIPs included Adult Access to Preventive Health Care and Hospital Readmissions. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements.

**Table 29: Absolute Total Care PIP Validation Results**

| Adult Access to Preventive Health Care (AAP) | |
|---|---|
| The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The baseline rate was CY2020 with a rate of 77.28%. The rate improved at remeasurement 1 (CY2021) to 78.18%. The goal is 81.97%. | |
| **Previous Validation Score** | **Current Validation Score** |
| Not submitted | 80/80=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits so they are well versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care.<br>• Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, member newsletters, and new member welcome packets to improve member knowledge and understanding of appointment availability standards.<br>• Member outreach staff educate members on the importance of seeing their provider to receive recommended services.<br>• Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. | |

- Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility.
- ATC will utilize a vendor, Eliza, to supplement outreach by the Quality Department staff to assist with scheduling appointments.
- Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services.
- Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.

**Hospital Readmissions**

The Readmissions PIP aims to reduce annual rate of readmissions within 30 days for 18–64-year old patients. The baseline rate was 18%, which was reduced to 16.2%, and further reduced to 15.5% for remeasurement 2 (ending June 2022). The goal was to reduce the rate to 15.5% and the goal was therefore met.

| Previous Validation Score | Current Validation Score |
|---|---|
| 72/72=100%<br>High Confidence in Reported Results | 80/80=100%<br>High Confidence in Reported Results |

**Interventions**

- Transition of Care (TOC) team assesses members upon discharge and reviews the discharge summary, assists member with scheduling appointment within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. Quarterly meetings are held with managers and the TOC team to discuss the TOC process.
- Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions.
- For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP.
- Members at risk for readmission based on most frequently admitted diagnosis are referred to the Case Manager or to Intensive Care Coordination for outreach if not actively enrolled in case management.
- Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meet quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members.
- UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met.

Humana submitted two PIPs for validation. Topics included Human Papillomavirus Vaccine (HPV) and Prenatal and Postpartum Compliance. The PIPs met the validation requirements and received scores within the "High Confidence Range."

**Table 30: Humana PIP Validation Results**

| Human Papillomavirus Vaccine (HPV) | |
|---|---|
| According to the 2018 South Carolina Health Assessment, South Carolina ranks in the lowest quartile nationally for adolescents having received one or more doses of the HPV vaccine. As of April 2022, 22% of Humana's Healthy Horizons population is between the ages of 7 and 13. Well child visit compliance rates tend to decrease for this age group. Although vaccine rates continue to rise in SC, unfortunately, the rates for HPV immunizations have not increased at the rate of other vaccines in SC or the US. The importance of this PIP is to increase the complete uptake of HPV vaccines by educating adolescents, parents, and providers on the importance of preventing cancer and the common misconceptions of the HPV vaccine. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the HPV vaccines to 38.44%. The PIP report showed a rate of 1.82% in Q3 which was the MY 2021 final rate and 3.85% in Q4 which is the interim MY 2022 rate. This was an improvement toward the goal rate of 36.5% (goal change for NCQA from 38.44% to 36.5%). | |
| **Previous Validation Score** | **Current Validation Score** |
| N/A | 79/79=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Update corporate HEDIS metric monitoring dashboard to include the SC health plan for data monitoring and tracking towards goals.<br>• Revise the Quality Improvement staffing to include a clinical compliance nurse and data analyst.<br>• Launch targeted outreach campaigns specific to EPSDT program offerings.<br>• Create targeted member education materials for targeted outreach.<br>• Draft and distribute a provider newsletter educating providers on HPV vaccine uptake importance and Value-Added Benefits.<br>• Draft and distribute member newsletters educating members on HPV vaccine importance, misconceptions and associated Value-Added Benefits. | |
| **Prenatal and Postpartum Compliance** | |
| The objective of the project is to increase the rate of eligible women receiving timely prenatal and postpartum care. Timely prenatal care is defined as care received within 42 days of enrollment or during the first trimester. Timely postpartum care is defined as care received between 7-84 days post-delivery. The prenatal goal is to increase the compliance rate of 84.49% to 85.4% and increase the postpartum goal from 57.59% to 77.37%. Although all members will be outreached, the target population measured will be all members who delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Members who did not have a live-birth and those using Hospice services anytime during the measurement year will be excluded. For the timeliness of prenatal care measure, the final MY2021 rate reported in Q3 was 100% (although the sample included only 3 women); the interim MY2022 rate was 84.49% (target rate 85.4%). This rate declined, although the denominator for the baseline was very small so the reliability of that rate is difficult to ascertain. For postpartum care measure, the baseline rate was 0%, which increased to 57.59% (interim MY 2022) with a goal of 77.37%. | |
| **Previous Validation Score** | **Current Validation Score** |
| N/A | 73/74=99%<br>High Confidence in Reported Results |

| Interventions |
| --- |
| • Enhance postpartum compliance education on the extension of the 12-month postpartum coverage through targeted Case Management services. Include a bi-lingual prenatal nurse to the Case Management staff.<br>• Educate providers on 12-month postpartum coverage through provider orientations, provider newsletters and quarterly touchpoints.<br>• Re-brand the prenatal/postpartum education materials for targeted outreach opportunities.<br>• Implement value added benefits that are targeted to both mom and baby for better access to resources and care.<br>• Enhance early intervention opportunities through population identification and clinical assessments.<br>• Update corporate HEDIS metric monitoring dashboard to include the SC health plan for data monitoring and tracking towards goals.<br>• Launch the Cultural and Linguistically Appropriate Services (CLAS) program as a structure for disparity analysis to include the prenatal/postpartum care HEDIS rates.<br>• Include a delivery date question for the identified population on the Health Risk Assessment tool.<br>• Add a clinical compliance nurse and data analyst to the Quality Improvement department. |

Humana's PIP reports had issues including how the document was organized and typos that needed to be resolved. One indicator for the Prenatal and Postpartum Compliance PIP declined. CCME provided the following recommendation for that PIP.

**Table 31: Humana's PIP Recommendation**

| Project | Section | Reason | Recommendation |
| --- | --- | --- | --- |
| Prenatal and Postpartum Compliance | Was there any documented, quantitative improvement in processes or outcomes of care? | Indicator 1 (timeliness of prenatal care) reduced from 100% to 84.49% with a goal of 85.40%. Indicator 2 (postpartum care) improved from 0% to 57.49% with a goal of 77.37%. | Initiate additional interventions to improve prenatal and postpartum care measures and continue to track interim progress as new interventions are implemented. |

Select Health submitted two PIPs for validation. Topics for the PIPs included Comprehensive Diabetes Care Outcomes Measures and Well-Care Visits for Children and Adolescents in Foster Care in South Carolina. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements.

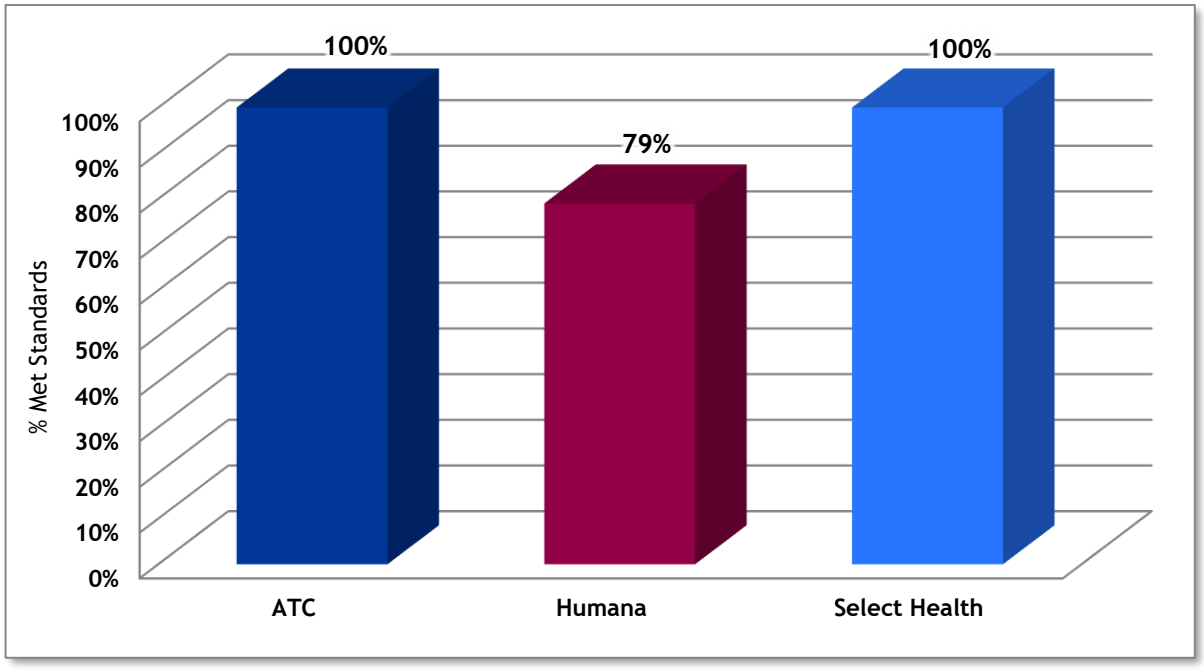
**Table 32: Select Health Humana PIP Validation Results**

| Comprehensive Diabetes Care Outcomes Measures | |
|---|---|
| The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8).<br>The Diabetes outcomes PIP showed improvement in the HBA1C <8% measures from 36.98% to 42.82%. The Blood Pressure Control (<140/90) improved in the latest remeasurement from 53.04% to 63.02%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 90/91= 99%<br>High Confidence in Reported Results | 91/91=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Data sharing by direct EMR access<br>• Year-round medical record review<br>• Value based payment programs<br>• Member incentives<br>• Provider education<br>• Newsletters | |
| **Well-Care Visits for Children and Adolescents in Foster Care in South Carolina** | |
| The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase the compliance with Well-Care visits for the children and adolescents in the foster care. During the pilot project, Select Health found there was no defined process point for sharing health, behavioral health, dental history, or detail prior to placement and no process for sharing information between Select Health and SC Department of Social Services (SCDSS) while the child is in placement. Another significant finding of the Health Care Pilot and Case Process Review was that, despite the fact that virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) Well-Child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits.<br>The Adolescent Well-Care rate declined from 71.11% to 69.59%. The Well-Child in the first 15 months (6+ visits) improved from 54.78% to 58.16%. The Well-Child visits in 3rd, 4th, 5th, and 6th years of life increased from 81.45% to 83.38%. W30 measure (Well-Child visits in the first 30 months of life (0 – 15 months) improved from 54.78% to 58.16%. The W30 for 15-30 months improved from 85.53% to 89.33%. The WCV for 3-11 years improved from 76.36% to 77.42%; for 12- 17 years it improved from 75.71% to 76.02%; for 18-21 it declined 46.41% to 38.46%. The total WCV rate declined 73.87% to 73.51% in 2021. | |
| **Previous Validation Score** | **Current Validation Score** |
| 91/91=100%<br>High Confidence in Reported Results | 91/91=100%<br>High Confidence in Reported Results |
| **Interventions** | |

- Data sharing
- Care management calls to new members
- Monthly gaps in care reports
- Clinical rounds
- Weekly appointment reports
- Provider education
- Foster Care Affinity Group meetings
- Select Health's Foster Care Team that works directly with 17-year-olds.

Overall, the plans performed well in the QI section. *Figure 9: Quality Improvement* provides an overview of the plans' performance in the QI section. Humana had weaknesses with their QI Program structure, QI Committee, and program evaluation.

**Figure 9: Quality Improvement**




A comparison of the plans' scores for the standards in the Quality Improvement section is illustrated in *Table 33: Quality Improvement Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 33: Quality Improvement Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The Quality Improvement (QI) Program<br>*42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)* | | | | |
| 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 | Met | Partially Met ↓ | Met | **Strengths:**<br>▶ ATC's and Select Health's QI Program Descriptions were detailed and included all required elements.<br>▶ Each MCO provided information to members and providers about their QI programs via their websites, in the Member Handbooks and in the Provider Manuals.<br><br>**Weaknesses:**<br>▶ Humana's QI Program Description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships).<br><br>**Recommendations:**<br>• Humana's QI Program Description should be updated and include the program's structure related to the staff assigned to the QI program and their responsibilities. |
| The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems | Met | Met | Met | |
| 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) | Met | Met | Met | |
| Quality Improvement Committee | | | | |
| The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities | Met | Met | Met | **Strengths:**<br>▶ The Quality committee minutes were well documented. |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The composition of the QI Committee reflects the membership required by the contract | Met | Not Met ↓ | Met | **Weaknesses:**<br>▶ Humana's Quality Assurance Committee did not include a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2.*<br><br>**Recommendations:**<br>• Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee. |
| The QI Committee meets at regular quarterly intervals | Met | Met | Met | |
| Minutes are maintained that document proceedings of the QI Committee | Met | Met | Met | |
| Performance Measures<br>*42 CFR §438.330 (c) and §457.1240 (b)* | | | | |
| Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures" | Met | Met | Met | **Strengths:**<br>▶ The MCOs were fully compliant with all information system standards and submitted valid and reportable rates for all HEDIS measures in the scope of the audit. |
| Quality Improvement Projects<br>*42 CFR §438.330 (d) and §457.1240 (b)* | | | | |
| Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population | Met | Met | Met | **Strengths:**<br>▶ PIPs were based on analysis of comprehensive aspects of member needs and services, and rationale for each topic was documented.<br>▶ All PIPs met the validation requirements and received validation scores within the High Confidence Range. |
| The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects" | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Provider Participation in QI Activities | | | | |
| The MCO requires its providers to actively participate in QI activities | Met | Met | Met | **Strengths:**<br>▶ Results of provider performance is shared through various quality reports, dashboards, provider report cards and gaps in care reports. |
| Providers receive interpretation of their QI performance data and feedback regarding QI activities | Met | Met ↑ | Met | |
| Annual Evaluation of the QI Program<br>*42 CFR §438.330 (e)(2) and §457.1240 (b)* | | | | |
| A written summary and assessment of the effectiveness of the QI program for the year is prepared annually | Met | Partially Met ↓ | Met | **Weaknesses:**<br>▶ Humana's 2021 – 2022 Quality Improvement Evaluation did not include the results of all activities and contained errors. |
| The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors | Met | Met | Met | **Recommendations:**<br>• Correct the errors in Humana's QI Program Evaluation and include the results of all activities completed and/or an update for the ongoing activities. |

## 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)*

ATC , Humana, and Select Health have appropriate program descriptions, policies, and guidelines that describe how utilization management (UM) services are operationalized for physical health, behavioral health, and pharmaceutical services for members. The program's purpose, goals, objectives, and staff roles are described appropriately in the MCOs' respective program descriptions and polices. Although page five of Humana's UM Program Description indicates the Quality Assessment Committee provides monitoring, oversight, and direction of the UM Program, staff reported during the onsite that the Quality Assurance Committee is responsible for this oversight. This was identified in Humana's 2022 UM Program Description during the previous EQR. CCME recommended Humana correct the UM Program Description; however, that change was not made in the 2023 UM Program Description.

During the 2022 EQR, Humana had issues with policies that contradicted the timeliness requirement for UM decisions. Humana addressed this deficiency by removing the polices that were not applicable to the SC line of business. *Table 34: 2022 EQR Utilization Management Program Deficiency – Humana* provides an overview of this issue and Humana's response.

**Table 34: 2022 EQR Utilization Management Program Deficiency - Humana**

| Standard | EQR Comments |
|---|---|
| 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:<br><br>1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification; | The timeliness for Utilization Management decisions is included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Requests for non-urgent standard authorizations are reviewed within 14 calendar days following receipt of the request for service. Urgent requests for authorization are reviewed within 72 hours after receipt of the request.<br>Focus Health, Inc. provides Behavioral Health Utilization Management Reviews. The Focus policy, Initial Case Review V 14.0, contained the timeframes for completing requests for peer reviews. This policy incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the SCDHHS MCO Policy and Procedure Guide, 4.2.24.<br>*Quality Improvement Plan: Correct the timeframes for completing non-expedited reviews and include the 14-day extension* |

| Standard | EQR Comments |
|---|---|
| | *requirements and the specific timeframes for completing a request for Substance Abuse treatments in the Focus policy, Initial Case Review V 14.0.* |
| **Humana's Response:** Humana has removed the Focus policy presented. The Focus policy is not applicable to SC Medicaid and Focus is not a delegated vendor for UM. The correct policy to meet this requirement is UM Determinations and Notifications- 005.<br>**05/17/2022**: Utilization Management for Behavioral Health Services is managed by Humana's internal Medicaid Utilization Management team. | |

Each health plan's Chief Medical Officer/Medical Director provides oversight of the UM Program. The responsibilities for this position are to provide oversight of the UM Program, conduct Level II Reviews, participate in peer-to-peer consultations, etc. The health plans also have licensed clinical directors for each program.

UM staff responsible for conducting Level I medical necessity reviews include clinical associates that are nurses or behavioral health professionals. Non-clinical associates may receive and perform data entry of requests from providers and process authorization requests that do not require a clinical review.

### *Coverage and Authorization of Services*

*42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*

Various policies and guidelines provide guidance to staff in making clinical determinations. Each health plan uses evidence-based guidelines such as InterQual, Milliman Care Guidelines, American Society of Addiction Medicine (ASAM), etc. for conducting initial reviews.

To ensure consistency in clinical application for review staff, each health plan conducts annual Inter-Rater Reliability (IRR) testing for physicians and non-physician clinical reviewers. For the 2022 EQR, Humana had not implemented the IRR process as noted in *Table 35: 2022 EQR Deficiency Related to IRR - Humana*. The current EQR revealed that Humana conducted IRR testing and provided the results of their most recent IRR testing.

**Table 35: 2022 EQR Deficiency Related to IRR - Humana**

| Standard | EQR Comments |
|---|---|
| **V B. Medical Necessity Determinations** | |
| 5. Utilization management standards/criteria are consistently applied to all members across all reviewers. | Humana's UM Program Description provided a summary of the Inter-rater Reliability monitoring process used to assess consistent decision-making for all staff who render clinical determinations. The goal is an overall average score of 85% for physicians and 90% for non-physician reviewers. To date Humana has not conducted IRR |

| Standard | EQR Comments |
|---|---|
| | testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.<br>*Quality Improvement Plan: Conduct IRR testing for all staff who render clinical determinations.* |
| **Humana's Response:** Humana's IRR testing is scheduled for 05/06/2022. | |

CCME reviewed a sample of approval and denial files for each health plan. Overall, review of the approval files reflected use of appropriate criteria when making clinical determinations. Additionally, the clinical determinations were completed within the required contractual guidelines for standard and expedited requests. Review of the denial files confirmed that denial decisions were communicated timely to members and providers. However, issues were identified for each health plan:

- ATC—In one file, additional information was requested after completion of the review decision. In two denial files, the adverse benefit determination notices incorrectly indicated that a written appeal is required within 14 days of an oral appeal request. However, this is no longer a contractual requirement. During the onsite discussion, ATC staff reported they had already identified this as a concern and noted there were two different versions of the Adverse Benefit Determination notice in the system. Staff were not consistent in utilizing the updated notice. ATC described actions taken to address the issue by removing the old letter template from the system.
- Humana—Denial files revealed inconsistency in the timeframes allowed for providers to submit information when additional information was requested. The UM Program Description (page 10) indicates two attempts will be made to obtain additional information from the provider. Humana described this process during the onsite. It was mentioned that if a medical director receives a second level review with insufficient or no clinical information available, if a minimum of two attempts to obtain this information was made, and it has been at least one business day since the date of the request, the Medical Director will issue a denial. Some of the files lacked documentation of those two attempts, the timeframe the provider was given for submitting the additional information, and/or whether the additional information was received.
- Select Health—One denial file was not completed within the required timeframe of 14 days for standard requests.

ATC, Humana, and Select Health have several letter templates used for notifying members and providers of a denial decision. For the 2022 EQR of Humana, there were errors identified in Humana's Adverse Benefit Notices as reflected in the table that follows.

**Table 36: Previous Deficiency Related to Adverse Benefit Notifications - Humana**

| Standard | EQR Comments |
|---|---|
| **V B. Medical Necessity Determinations** | |
| **11. Denials**<br><br>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. | Humana provided several letter templates for notifying providers and members of adverse benefit determinations. The Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days when requested by the member or by the plan. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation to the member for when to use this contact information.<br>*Quality Improvement Plan: Correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.* |
| **Humana's Response:** Humana has rewritten the letters to include all corrections sited. The letters have been submitted to the SCDHHS for final approval. | |

For the 2023 EQR, Humana provided several letter templates for notifying providers and members of adverse benefit determinations. Humana corrected the errors previously identified by CCME. However, the old notices were found in some of the denial files reviewed. Humana explained the corrected letters were approved and implemented in May/June 2022. The incorrect letters identified in the files reviewed by CCME occurred before June 2022.

Each health plan also provided a Pharmacy Description that outlines the guidelines of the UM Pharmacy Program.

The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plans to publish negative PDL changes on their website at least 30 days prior to implementation. For the 2022 EQR, CCME found ATC and Humana did not meet this requirement. Both Health Plans updated the template for posting PDL changes to the website and met SCDHHS' requirement for posting negative PDL changes. The tables that follow provide an overview of the deficiencies and include ATC's and Humana's responses.

**Table 37: ATC's 2022 Medical Necessity Determination Deficiency and Response**

| Standard | EQR Comments |
|---|---|
| Medical Necessity Determinations | |
| 6.1 Any pharmacy formulary restrictions are reasonable and are | Policy CC.PHAR.10, Preferred Drug List, describes ATC's policy for maintaining the Preferred Drug List and identifying pharmaceutical management controls to ensure appropriate use of the health plan's |

| Standard | EQR Comments |
|---|---|
| made in consultation with pharmaceutical experts. | pharmacy benefit. The Preferred Drug List provides formulary restrictions and indicates medications requiring prior authorization, limitations, or step therapy. Processes for members to obtain over-the-counter medications are described in the Member Handbook.<br>Per Policy CC.PHAR.10, Preferred Drug List, negative PDL changes are communicated to affected members and their prescribing practitioners at least 30 days in advance via the health plan website. However, some of the issues identified with this notification included:<br>•The Pharmacy and Therapeutics (P&T) Committee met and approved the PDL changes after the effective date of the change. For example, 2nd quarter 2020 changes had an effective date of March 1, 2020. The changes were discussed at the P&T Committee meeting held on March 7, 2020.<br>•1st quarter 2021 changes had an effective date of February 1, 2021. These changes were discussed at the P&T Committee meeting on January 12, 2021, which only gave a 20-day notice. Also, there were PDL changes discussed during the meeting and not included on the website notice.<br>•Several changes noted in the 1st quarter 2021 P&T Committee meeting minutes (meeting date January 12, 2021) had an effective date of December 1, 2020; however, no notice was found on the website (Procysbi and Rukobia). Semglee was discussed during the January 12, 2021, P&T meeting and posted on the website; however, the effective date was January 1, 2021, which was before the committee met.<br>*Quality Improvement Plan: Address in a policy or desk procedure the process for ensuring negative PDL changes are published on the website at least 30 days prior to implementation as required by SCDHHS Contract, Section 4.2.21.2.3. Ensure members and their prescribing practitioners are notified at least 30 days in advance of negative PDL changes via the health plan website. Consider including the date the notices are published on the website.* |
| **ATC's Response:** Pharmacy Department staff will be provided with a copy of the new desk procedure which will outline in detail the steps that need to be taken any time a negative change is made to the PDL. This workflow will reemphasize the minimum thirty-day advance notice to members and providers required in the contract with the State, and also the minimum thirty day posting of the changes to the website of any negative changes to the PDL as required. A new template has been created to address the issue that only effective date was listed previously on the PDL change documents listed on the website. The new template will have both the posted date (or date the PDL change document was posted on the website) and the effective date (or the date that the changes will be effective). This new template will make it easy to determine if regulatory deadlines regarding posting were met when negative changes are made to the PDL. | |

**Table 38: Humana's 2022 Medical Necessity Determination Deficiency and Response**

| Standard | EQR Comments |
|---|---|
| **V B. Medical Necessity Determinations** | |
| 6. Pharmacy Requirements<br><br>6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts. | The Pharmacy Program Description provides an overview and structure of Humana's pharmacy program. The Preferred Drug List (PDL) identifies formulary restrictions by indicating medications requiring prior approval, limitations, and/or step therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL.<br>The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List (PDL) changes on Humana's website at least 30 days prior to implementation. Policy (Formulary Change Notification Process)-005, defines how Humana notifies affected parties of changes to the formulary. Notices for PDL changes were found on Humana's website; however, the effective date for the change and when the notice was published on the website were unclear. The notice contained a date at the top of the page without an explanation of what this date represents.<br>*Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Humana's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.* |
| **Humana's Response:** Humana has updated the template for negative PDL changes. The updated template identifies the date posted and the effective date. As of 03/22/2022 the updated template will be used. | |

Additionally, Humana's process for prior authorization requests for medications is discussed in the Pharmacy Program Description, which mentions providers receive a determination notification within 24 hours of a request for prior authorization. The *SCDHHS Contract, Section 4.2.21.3.2* requires the health plan to authorize a 72-hour emergency supply of medications to members in emergent situations until a prior authorization decision is received. There was no mention of this requirement in Humana's policy, Pharmacy Program Description, Member Handbook, or Provider Manual. During onsite discussion, the health plan was able to describe the process when an emergency supply is needed; however, this process is not documented.

Lastly, PerformRx is Select Health's Pharmacy Benefit Manager and is integrated into the pharmacy program to manage pharmaceutical authorizations. PerformRx updates pharmacy information on Select Health's website, which included a copy of the 2022 Preferred Drug List Changes.

### *Appeals*

*42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*

ATC, Humana, and Select Health are responsible for processing and managing appeals. Various policies along with the UM Program Descriptions, Provider Manuals, and Member Handbooks outline each health plan's appeal process and define the terms "adverse benefit determination" and "appeal." However, two issues were identified in Select Health's appeal process. Those included:

- The Provider Manual states appeals are acknowledged within one business day. This is inconsistent with Policy MMS.100, Members Grievances and Appeals Process, which indicates appeals are acknowledged within five business days. During the onsite discussion, Select Health staff reported that one business day is an internal goal.

- The Expedited Appeal Request Denial letter template states "For a standard appeal to be complete, you must make a request in writing. We must get the written appeal within 30 calendar days of your verbal request." This letter was addressed during the onsite discussion; the MCO acknowledged awareness that this is no longer a contractual requirement and reported the wrong letter template was submitted. However, the resubmitted Expedited Appeal Request Denial Letter Template continues to cite the previously stated language that a written appeal is required within 30 calendar days of a verbal request.

CCME conducted a review of the appeals files, and findings reflected various strengths and weaknesses. ATC appeals files reflected that the appeal guidelines and processes were followed according to contractual standards.

**Humana** provided a sample of appeal files for review. The following issues were identified:

- The resolution notices for five files indicated the decision was made by a specialist in the Grievance and Appeal Department or by a medical director. However, the decisions were made by a consultant with the Network Medial Review Company.

- The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. References to medical literature and medical terminology, such as "tardive dyskinesia," "neuroendocrine tumors," and "hypereosinophilic syndrome" were included in the resolution letters.

- Also, three expedited appeal requests were not resolved within the 72-hour timeframe. In two of the files, it appeared the physician reviewer used a KY administrative code and a KY fee schedule for making the determination.

As reflected in the table below, these were the same issues identified during Humana's 2022 EQR and not corrected.

**Table 39: Previous EQR Appeals Deficiencies and Response for Humana**

| Standard | EQR Comments |
|---|---|
| **V C. Appeals** | |
| 2. The MCO applies the appeal policies and procedures as formulated. | Humana provided one appeal file. The file reflected the acknowledgement and resolution was completed timely. An appropriate physician reviewed the file and made the decision to uphold the original denial. The resolution notice contained the following errors.<br>•The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal."<br>•Also, the language used to describe why the denial was upheld appeared to be above the 6th grade reading level.<br><br>*Quality Improvement Plan: Develop a process for monitoring resolution notices to ensure the letter contains correct reviewer information and the language meets the SCDHHS 6th reading level.* |
| **Humana's Response:** Humana's G&A team has a process to run the Flesch- Kincaid tool after the clinical decision has been determined to ensure it meets the 6th-grade reading level. | |

**Select Health's** review of the appeals files also identified some issues. There were four files for which the notifications sent to the member were incorrect. The identified issues included:

- The acknowledgement letters for three expedited appeal files incorrectly indicated the appeals would be resolved in thirty days as opposed to 72 hours.
- For one file, the notice sent to the member incorrectly informed the member that the reason for closing the appeal was due to the member not submitting a written appeal after a verbal request. There was no mention in the file of Select Health requesting a written appeal. The file indicated that Select Health requested member consent for the provider to appeal on their behalf. The member's consent was not received.

These files were discussed during the onsite visit. Select Health acknowledged there were issues with the acknowledgment letters being sent to members. Select Health indicated the process had changed and no acknowledgement letters were being sent for expedited appeals. Staff were instructed to document verbal acknowledgement in the appeal review system. However, there were no notes provided in the files to indicate this was

being documented as described. Select Health also indicated their internal process had changed and all acknowledgement letters would be sent directly from the Appeals Team. This change will assist in preventing these administrative errors in the future.

### *Case Management*

*42 CFR § 208, 42 CFR § 457.1230 (c)*

ATC, Humana, and Select Health's UM Case Management (CM) Program Descriptions, UM Program Descriptions, Provider Manuals, Member Handbooks, and various policies provide a descriptive overview and approaches for providing CM services to members. Members may self-refer for CM services and referrals may also come through various sources such as providers, vendors, delegated entities, etc. ATC and Select Health reported that predictive modeling is utilized to aid in identifying potential members for CM services. Humana indicated that the health plan does not currently have predictive modeling software to identify members for care management but has plans to implement a predictive modeling tool by the end of the year. In the interim, Humana described that hospital data, claims, direct referrals, etc. are utilized to identify members for potential care management.

CCME conducted a file review of CM files and found that, overall, CM activities are performed as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources. However, there was an issue with care coordination for Humana's files. For one CM file reviewed, the member was engaged in CM and required an inpatient admission. The case was closed as unable to contact. Onsite discussion with the health plan described the process for closing cases when care managers are unable to contact members. According to Humana, two telephone attempts are made and a letter is sent within a two-week period before a member's case is closed. This process was not followed, as the member's case was closed within one week of the first initiated telephone call. Also, in one file, the member was not informed of their right to opt in or out of the care management program.

### *Over/Under Utilization*

ATC, Humana, and Select Health have outlined policies and guidelines in analyzing trends and patterns for over and underutilization.

As reflected in *Table 40: Humana 2022 EQR Over/Underutilization Deficiency and Response*, Humana had a previous deficiency during the 2022 EQR related to not having a process in monitoring over and underutilization data. Humana adequately addressed this issue by developing an Over and Under Utilization Data Plan policy.

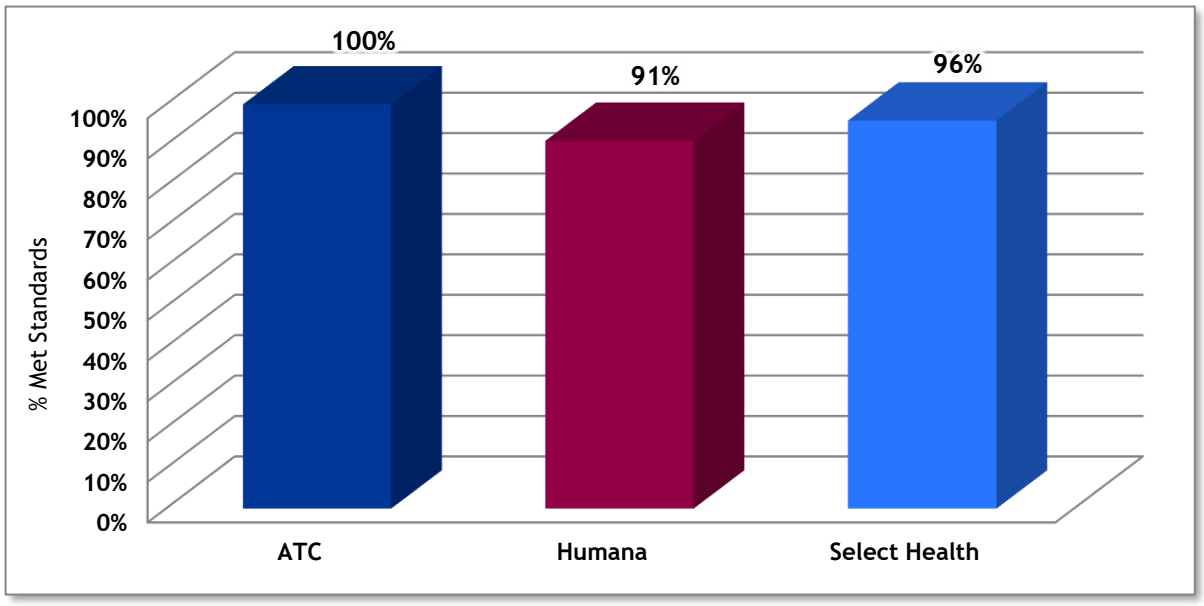
**Table 40: Humana 2022 EQR Over/Underutilization Deficiency and Response**

| Standard | EQR Comments |
|---|---|
| **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 | Policies for drug utilization, the Utilization Management Data Plan and the Fraud, Research, Analytics and Concepts report for fraud management was submitted. The utilization management data plan offered some utilization indicators that will be monitored, including acute admits per 1000, inpatient days per 1000, readmission rates, ER visits per 1000 and others. All monitoring and assessment will be done by the Medical Management team and shared with Quality Management team. There was not a specific policy or action steps planned for addressing over and underutilization. This was an issue identified during the Readiness Review. In response to this deficiency, the Utilization Management Data Plan stated that the Medical Management Committee "creates plans to mitigate when issues are identified." However, the process for how that is conducted was not clearly documented. During the onsite, staff indicated the Utilization Management Team was still building this out.<br>*Quality Improvement Plan: Provide more detail in the Utilization Management Data Plan regarding issues identified during the monitoring of over or underutilization. The data plan should include steps If monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.* |
| **Humana's Response:** Humana developed an Over and Under Utilization Data Plan policy in place of the Utilization Data plan. This policy was created by UM and the Quality team. Both teams will annually review this policy and monitor the plans over and underutilization. The policy addresses steps If monitoring shows a trend of over or under a target value. The updated policy addresses the steps used to ensure movement toward appropriate utilization is taken, includes responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues. | |

Humana's Policy SC CLI 006, Over and Under Utilization Data Plan, offers procedures for utilization anomalies. CCME reviewed the monthly data for admissions, length of stays, readmissions, ER visits, and urgent care visits. The results, as of October 2022, showed an increase for admissions, length of stay, readmissions, and ER Visits. The report submitted to the Quality Assurance Committee offers frequencies or rates for the utilization data. However, clear goals for the utilization measures were not provided. Without goals or target rates, concerns may not be identified in terms of being over or under a goal.

A comparison of the percentage of "Met" scores for the UM section is illustrated in *Figure 10: Utilization Management*.

**Figure 10: Utilization Management**




A comparison of the plans' scores for the standards in the Utilization Management section is illustrated in *Table 41: Utilization Management Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 41: Utilization Management Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The Utilization Management (UM) Program | | | | |
| The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to | Met | Partially Met ↓ | Met | **Strengths:**<br>▶ The health plans have detailed UM Program Descriptions and policies that define and describe the UM process and supervision oversight that is provided to staff.<br><br>**Weaknesses:**<br>▶ Humana's committee responsible for the oversight of the UM Program is incorrect in the 2023 UM Program Description.<br>▶ Humana's 2023 Pharmacy Program Description identifies Humana Pharmacy Solutions as the pharmacy benefit manager. However, page 15 of the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager.<br>▶ Humana's policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 were draft policies that contained tracked changes even though it was recommended last year that these policies be finalized. |
| Structure of the program and methodology used to evaluate the medical necessity | Met | Met | Met | |
| Lines of responsibility and accountability | Met | Met | Met | |
| Guidelines / standards to be used in making utilization management decisions | Met | Partially Met ↓ | Met | |
| Timeliness of UM decisions, initial notification, and written (or electronic) verification | Met | Met ↑ | Met | |
| Consideration of new technology | Met | Met | Met | |
| The absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services | Met | Met | Met | |
| The mechanism to provide for a preferred provider program | Met | Met | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee | Met | Met | Met | **Recommendations:**<br>• Correct the deficiencies in Humana's UM Program Description and remove the references to the Quality Assessment Committee. Also, verify the pharmacy benefit manager for SC and correct the UM Program Description, Pharmacy Program Description, and/or Humana's website.<br>• Humana - Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002, finalize the tracked changes, and remove the draft watermark. |
| 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 | Met | Met | Met | |
| Medical Necessity Determinations<br>*42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228* | | | | |
| Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations | Met | Met | Met | **Strengths:**<br>▶ All approval files were completed in a timely manner according to contractual requirements.<br>▶ ATC provided a Member Authorization Form and Member Appeal Form with the adverse benefit determination notices for member convenience.<br>▶ Humana conducts denial letter audits in real time for quality assurance and supervision opportunities as needed for UM reviewers.<br>▶ Inter Rater Reliability testing results yielded a 90% or higher score for all health plans and exceeded the desired benchmark.<br>▶ ATC's and Select Health's denial letters were clear and understandable in identifying the rationale for the adverse benefit determination. |
| Utilization management decisions are made using predetermined standards/criteria and all available medical information | Met | Met | Met | |
| Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations | Met | Met | Met | |
| Utilization management standards/criteria are reasonable and allow for unique individual patient decisions | Met | Met | Met | |
| Utilization management standards/criteria are consistently applied to all members across all reviewers | Met | Met ↑ | Met | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts | Met ↑ | Met ↑ | Met | **Weaknesses:**<br>▶ The *SCDHHS Contract, Section 4.2.21.3.2* requires the health plan to authorize a 72-hour emergency supply of medications to members in emergent situations until a prior authorization decision is received. Humana did not have a process outlined to meet this requirement in the Pharmacy Program Description, the Member Handbook, Provider Manual, or in a policy.<br><br>**Recommendations:**<br>• Humana - Include the process followed to authorize a 72-hour supply of medication to members in emergent situations as required by the *SCDHHS Contract, Section 4.2.21.3.2* in a policy and the Pharmacy Program Description. |
| If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity | Met | Partially Met ↓ | Met | |
| Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations | Met | Met | Met | |
| Utilization management standards/criteria are available to providers | Met | Met | Met | |
| Utilization management decisions are made by appropriately trained reviewers | Met | Met | Met | |
| Initial utilization decisions are made promptly after all necessary information is received | Met | Met | Met | |
| 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 | Met | Met | Met | |
| All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist | Met | Met | Met | |
| Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal | Met | Met ↑ | Met | |
| Appeals<br>*42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260* | | | | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| 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 | Met | Met | Met | **Strengths:**<br>▶ Humana members can complete their appeal requests online and track the process through the online portal.<br><br>**Weaknesses:**<br>▶ Select Health's Provider Manual and policy were inconsistent regarding the timeframe for acknowledging an appeal.<br>▶ Select Health's Expedited Appeal Request Denial letter template incorrectly states that a verbal appeal request must be followed with a written appeal request.<br>▶ Humana and Select Health did not consistently process standard and expedited appeals according to guidelines in their policies and in federal regulations.<br><br>**Recommendations:**<br>• Select Health should align the timeframes for acknowledging an appeal in the Provider Manual and in policies. The requirement that a verbal appeal request must be followed with a written appeal request should be removed from all documents.<br>• Ensure the appeals process is consistently implemented according to contractual guidelines and federal regulations. |
| The definitions of an adverse benefit determination and an appeal and who may file an appeal | Met | Met | Met | |
| The procedure for filing an appeal | Met | Met | Partially Met ↓ | |
| 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 | Met | Met | Met | |
| A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay | Met | Met | Met | |
| Timeliness guidelines for resolution of the appeal as specified in the contract; | Met | Met | Met | |
| Written notice of the appeal resolution as required by the contract | Met | Met | Met | |
| Other requirements as specified in the contract | Met | Met | Met | |
| The MCO applies the appeal policies and procedures as formulated | Met | Not Met↓ | Partially Met ↓ | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee | Met | Met | Met | |
| Appeals are managed in accordance with the MCO confidentiality policies and procedures | Met | Met | Met | |
| Case Management<br>*42 CFR § 208, 42 CFR § 457.1230 (c)* | | | | |
| The MCO formulates policies and procedures that describe its case management/care coordination programs | Met | Met | Met | **Strengths:**<br>▶ The health plans' care management staff conducted appropriate care management activities for members in all risk levels.<br>▶ Select Health special population programs, such as Bright Start Maternity Care Coordination, Select Health Foster Care Program, and Emergency Diversion, are designed to provide targeted and specialized care to members. |
| The MCO has processes to identify members who may benefit from case management | Met | Met | Met | |
| The MCO provides care management activities based on the member's risk stratification | Met | Met | Met | |
| The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members | Met | Met | Met | |
| The MCO conducts required care management activities for members receiving behavioral health services. | Met | Met | Met | |
| The MCO has developed and implemented policies and procedures that address transition of care | Met | Met | Met | |
| The MCO has a designated Transition Coordinator who meets contract requirements | Met | Met | Met | |
| The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary | Met | Met | Met | |
| Care management and coordination activities are conducted as required | Met | Met | Met | |
| Evaluation of Over/Underutilization | | | | |

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract | Met | Met ↑ | Met | |
| The MCO monitors and analyzes utilization data for under and over utilization | Met | Met | Met | |

## F. Delegation

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

CCME's review of delegation functions included the delegate lists provided by the MCOs, sample delegation contracts, delegation monitoring materials, and documentation of delegation oversight.

ATC reported delegation agreements with 25 entities listed in *Table 42: Delegated Entities and Services – ATC*.

**Table 42: Delegated Entities and Services – ATC**

| Delegated Entities | Delegated Services |
|---|---|
| Envolve People Care - Behavioral Health | Behavioral Health Service Authorizations and Denials, Member and Provider Denial Letters, and Provider Generated Complaints |
| Envolve People Care – Nurse Advice Line | Member and Provider Calls, Nurse Hotline, and Triage |
| Envolve People Care - Disease Management | Disease Management |
| Centene Pharmacy Solutions | UM Service Authorizations, Provider Denial Letters, Provider Generated Complaints, Claims Adjudication, and Network Development and Maintenance |
| CVS Caremark | Pharmacy Claims |
| Envolve Vision | Claims Adjudication, Provider Claim Appeals, Credentialing, Recredentialing, and Network Development and Maintenance |
| NIA | UM Service Authorizations, Member and Provider Denial Letters, Credentialing, Recredentialing, and Network Development and Maintenance |
| Turning Point | UM Service Authorizations |
| New Century Health | UM Service Authorizations |
| • CVS Health<br>• Lexington<br>• MUSC<br>• RHP Spartanburg<br>• Roper St. Frances Physicians Network<br>• United Physicians<br>• AnMed Health<br>• AU Medical Center<br>• Bon Secours | Credentialing and Recredentialing |

| Delegated Entities | Delegated Services |
|---|---|
| • GHS Prisma Health<br>• MNS<br>• Palmetto Health USC<br>• Self Regional Health Care<br>• HNS<br>• Preferred Care of Aiken<br>• St. Francis Bon Secours | |

Humana reported delegation agreements with 20 entities, as shown in *Table 43: Delegated Entities and Services – Humana*.

**Table 43: Delegated Entities and Services – Humana**

| Delegated Entities | Delegated Services |
|---|---|
| InforMedia Group, Inc. dba CareNet Healthcare Services | 24/7 Nurse Advice Hotline |
| Focus Health Inc. dba Focus Behavioral Health Inc. | Appeal Determinations and Utilization Management |
| Network Medical Review Company, LTD | Appeal Determinations and Utilization Management |
| Braillet Corporation | ASL and Verbal Translation Services |
| Streamline Verify | Background Checks |
| • AnMed Health<br>• Medical University Hospital Authority/MUSC Medical Center<br>• Prisma Health University Medical Group<br>• Self Regional Healthcare<br>• South Carolina Department of Mental Health<br>• St. Francis Physician Services<br>• United Physicians Inc. | Credentialing and Recredentialing |
| Go365, LLC | Health Risk Assessments |
| Symphony Performance Health, Inc. dba SPH Analytics | Member Surveys |
| The MidIsland Group USA, LLC | Print and Mail Fulfillment |
| Voiance Language Services | Telephonic Translation Services |
| Harris Rothenberg, International | Tobacco Cessation and Weight Management Coaching |
| Modivcare Solutions, LLC | VAB, Nonemergent Transportation Services, and Claims Processing |

| Delegated Entities | Delegated Services |
|---|---|
| Block Vision, Inc. dba Superior Vision Benefit Management, Inc. | Vision Network Management, Claims Processing, and Credentialing |
| United Language Group, Inc. | Written Translation Services |

Select Health reported 13 delegation agreements, as shown in *Table 44: Delegated Entities and Services – Select Health*.

**Table 44: Delegated Entities and Services – Select Health**

| Delegated Entities | Delegated Services |
|---|---|
| National Imaging Associates (NIA) | Radiology UM |
| BHM Health Solutions | Behavioral Health decision reviews on assigned cases |
| PerformRx | Pharmacy UM |
| Infomedia Group dba Carenet Health Solutions | 24/7 Nurse Triage Line |
| • AU Medical Center<br>• Prisma Health<br>• Health Network Solutions (HNS)<br>• Medical University of South Carolina (MUSC)<br>• PSG Delegated Services<br>• Regional Health Plus (RHP)<br>• Roper St. Francis (RSF)<br>• St. Francis Physician Services (SFPS)<br>• Lexington Health, Inc. | Credentialing/Recredentialing |

Each of the health plans has policies that define delegation requirements as well as processes for evaluating potential delegates, approval of delegation, implementing written delegation agreements, and conducting ongoing monitoring and annual evaluations for existing delegates.

Prior to executing a delegation agreement, the health plans conduct pre-delegation assessments to evaluate potential delegates' abilities to conduct delegated activities in compliance with health plan standards and requirements of the *SCDHHS Contract*, NCQA, etc.

Upon completion of pre-delegation assessments and approval of delegation, the health plans execute written delegation agreements that specify the delegated activities as well

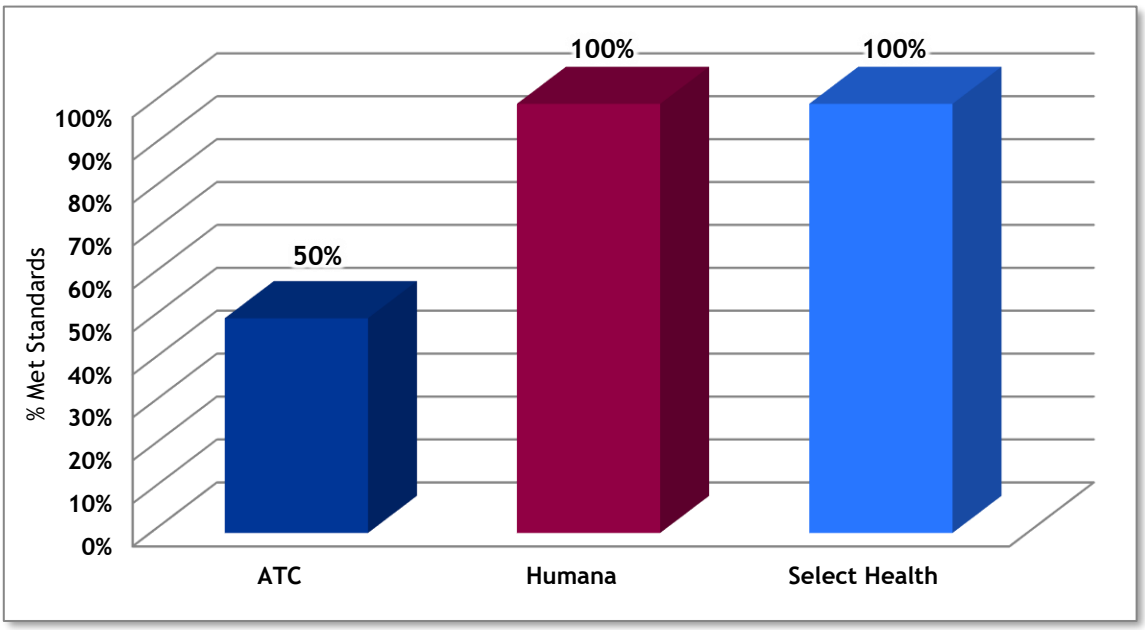
as health plan and delegate responsibilities, performance expectations, reporting requirements, and consequences for substandard performance and failure to fulfill obligations.

CCME reviewed the MCOs' documentation of oversight activities conducted for their delegates.

- For ATC, it was noted that the health plan did not provide evidence of the required annual evaluation for one delegate. Documentation of annual oversight for the remaining delegates included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions.
- Humana's documentation reflected timely annual oversight for all applicable delegates as well as routine reporting and meetings for all delegates. Annual oversight documentation reflected issuance of appropriate recommendations and corrective actions as needed, and follow-up of corrective actions.
- Select Health provided documentation of annual oversight for all delegated entities. The documentation included any deficiencies found, recommendations for improvement, and corrective action as needed.

*Figure 11: Delegation* displays the percentage of "Met" scores for the Delegation section for each MCO.

**Figure 11: Delegation**



A comparison of the plans' scores for the standards in the Delegation section is illustrated in *Table 45: Delegation Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 45: Delegation Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| Delegation<br>*42 CFR § 438.230 and 42 CFR § 457.1233(b)* | | | | |
| 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 | Met | Met | Met | **Strength:**<br>▶ Policies thoroughly document processes for pre-delegation assessments, approval of delegation, monitoring, and annual delegation oversight.<br>▶ Annual oversight documentation included appropriate audit and file review tools and documentation of results, recommendations, and any needed corrective actions.<br>▶ For Humana and Select Health, Oversight documentation submitted for review confirmed timely annual oversight for all applicable delegates, and routine reporting and meetings for all delegates.<br>**Weaknesses:**<br>▶ ATC did not provide annual oversight documentation for one delegate.<br>**Recommendations:**<br>• Ensure annual evaluations are conducted for each delegated entity. |
| 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 | Partially Met ↓ | Met | Met | |

## G. State Mandated Services

*42 CFR Part 441, Subpart B*

The review of State Mandated Services includes processes to track provider compliance with administering required immunizations and providing EPSDT/Well-Care services, the health plans' provision of member benefits, and the degree to which each health plan addressed previously identified deficiencies.

The reviews confirmed that each of the health plans provide all core benefits required by the *SCDHHS Contract*.

Providers are educated about EPSDT requirements and recommended immunizations and other preventive care recommendations through new provider orientations and ongoing education activities, Provider Manuals, health plan websites, newsletters, etc. Processes are in place to inform providers of members with gaps in care, and the MCOs evaluate provider compliance with provision of recommended immunizations and EPSDT services through medical record compliance audits and other activities, including monitoring of HEDIS reporting measures, population health dashboards, and UM reporting.

*Table 46: 2022 State Mandated Services QIP Items -- Humana* includes the issues that were identified during the previous EQR related to tracking provider compliance with immunization administration and provision of EPSDT/Well-Child services and Humana's response. The current EQR confirmed the deficiencies were appropriately addressed by Humana.

**Table 46: 2022 State Mandated Services QIP Items -- Humana**

| Standard | EQR Comments |
|---|---|
| **V I I. State Mandated Services** | |
| 1. The MCO tracks provider compliance with:<br>1.1 administering required immunizations; | Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations.<br>*Quality Improvement Plan: Implement activities to track provider compliance with administering required immunizations.* |
| **Humana's Response:** Humana tracks required immunization compliance with providers through various population health dashboards managed by key stakeholders within Humana. The dashboards allow for targeted compliance monitoring as well as education opportunities for the providers including reporting. | |
| 1.2 performing EPSDTs/Well Care. | Humana presented no evidence that it is currently tracking provider compliance with performing EPSDT/Well Care services.<br>Additionally, the *SCDHHS Contract, Section 4.2.10.1* states MCOs must "Have written Policies and Procedures consistent with *42 CFR 441, Subpart B*, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults." |

| Standard | EQR Comments |
|---|---|
| | *Quality Improvement Plan: Develop a written policy and procedure for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible members. Implement activities to track provider compliance with performing EPSDT/well care services for members.* |
| **Humana's Response:** Humana has an active ESPDT policy in place outlining the health plan's EPSDT process for tracking, monitoring, and education process for both members and providers. Provider Compliance is tracked through population health dashboards that include HEDIS metric compliance monitoring. | |

The annual review of each health plan includes determining whether the health plan addressed deficiencies identified during the previous year's EQR.

For ATC, it was confirmed that all issues identified during the previous EQR were addressed. *Table 47: Previous State Mandated Services QIP Items – ATC* displays the finding of the 2021 EQR related to uncorrected deficiencies and ATC's response to that finding.

**Table 47: 2021 State Mandated Services QIP Items – ATC**

| Standard | EQR Comments |
|---|---|
| **V I I. State Mandated Services** | |
| 3. The MCO addresses deficiencies identified in previous independent external quality reviews. | During the previous EQR, Geo Access mapping reports did not include all required SCDHHS-designated Status 1 provider types. In the current EQR, it was again noted that the Geo Access mapping reports did not include all required Status 1 provider types.<br>*Quality Improvement Plan: Ensure corrections for all deficiencies identified in the EQR are addressed and fully implemented.* |
| **ATC Response:** Compliance coordinates directly with all Business Owners to ensure that identified deficiencies are addressed. As an additional control for the GEO Access mapping report. Compliance has developed a checklist of Status 1 provider types and will review these reports to ensure all providers are addressed. | |

For Humana, it was found that Humana did not correct several deficiencies identified during the 2022 EQR. These were related to:

- References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy.
- Lack of a variety of participating network providers as members of the committee responsible for the Quality Improvement activities.

- Incorrect information in appeal resolution letters regarding who rendered the determination to uphold the original denial decision.

During the 2022 EQR, Humana was also noted to have uncorrected deficiencies from the Readiness Review conducted in 2021. *Table 48: Previous State Mandated Services QIP Items – Humana*, displays those previously uncorrected deficiencies and Humana's response.

**Table 48: 2022 State Mandated Services QIP Items – Humana**

| Standard | EQR Comments |
|---|---|
| **V I I. State Mandated Services** | |
| 3. The MCO addresses deficiencies identified in previous independent external quality reviews. | Humana did not implement the Quality Improvement Plans corrections to address the following deficiencies identified during the 2021 Readiness Review:<br>•Action was not taken to ensure credentialing and recredentialing files include full collaborative agreements between nurse practitioners and their supervising/collaborating physician.<br>•Action was not taken to ensure letters notifying providers of credentialing and recredentialing determinations are dated on or after the date of the credentialing/recredentialing determination.<br>•There were no specific policy or action steps planned for addressing the monitoring of over- and under-utilization.<br>*Quality Improvement Plan: Address and implement actions to correct all identified deficiencies.* |
| **Humana's Response:** Humana re-trained associates on 4/26/2022 to ensure collaborative agreements are included for nurse practitioners and their supervising/collaborating physician. Humana developed a new process that begins 5/12/2022 to better align credentialing and re-credentialing decisions and notification letter dates. Humana has developed a policy to address over and underutilization. Humana's Regulatory Compliance department will complete a pulse check in Q3 2022 on each newly implemented process. | |

During the 2021 EQR, Select Health was noted to have uncorrected deficiencies from the 2020 EQR. See *Table 49* below. For the 2022 EQR, findings indicate Select Health addressed all deficiencies from the 2021 EQR.

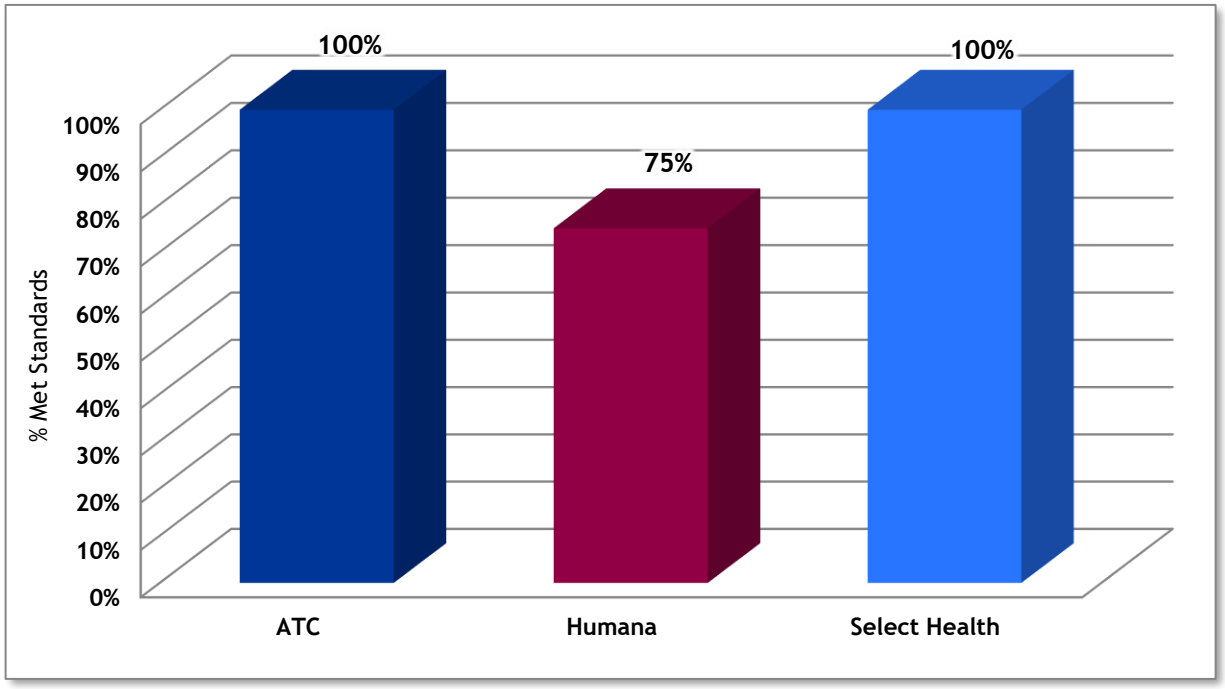
**Table 49: 2021 State Mandated Services QIP Items – Select Health**

| Standard | EQR Comments |
|---|---|
| **State Mandated Services** | |
| 3. The MCO addresses deficiencies identified in previous independent external quality reviews. | Issues identified during the previous EQR related to discrepancies in the timeframe for PCP appointment access and lack of improvement in the Telephonic Provider Access Study conducted by CCME were identified again during the current EQR. |

| Standard | EQR Comments |
|---|---|
| | Quality Improvement Plan: Implement actions to address all deficiencies identified in the EQR process. |
| **Select Health Response:** SHSC will implement actions to address all deficiencies identified during the EQR process by expanding on our efforts created in 2021 through the enforcement of the Compliance Auditing and Monitoring policy (SHC 168-002) approved in Q2 2022. Please see the attached approved policy and the SHSC 2022 audit plan schedule. | |

Each plan's percentage of "Met" scores is demonstrated in *Figure 12: State-Mandated Services*.

**Figure 12: State-Mandated Services**




A comparison of the plans' scores for the standards in the State Mandated Services section is illustrated in *Table 50: State Mandated Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

**Table 50: State-Mandated Services Comparative Data**

| Standard | ATC | Humana | Select Health | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|---|
| State Mandated Services<br>*42 CFR Part 441, Subpart B* | | | | |
| The MCO tracks provider compliance with administering required immunizations | Met | Met ↑ | Met | **Strengths:**<br>▶ Processes are in place for monitoring providers for provision of recommended EPSDT services and immunizations and informing providers of members with services due and care gaps.<br>▶ All required core benefits are provided to members.<br><br>**Weaknesses:**<br>▶ During the current EQR, CCME assessed the degree to which the health plans implemented actions to address deficiencies from the previous EQR and found that Humana did not implement Quality Improvement Plans for all previously identified deficiencies. d to:<br><br>**Recommendations:**<br>• Develop a plan of action to address and correct the deficiencies identified during this and previous EQRs. Include a monitoring component to ensure the plans are implemented timely and all deficiencies are corrected. |
| Performing EPSDTs/Well Care | Met | Met ↑ | Met | |
| Core benefits provided by the MCO include all those specified by the contract | Met | Met | Met | |
| The MCO addresses deficiencies identified in previous independent external quality reviews | Met ↑ | Not Met | Met ↑ | |

## H. Coordinated and Integrated Care Organizations Annual Review

SCDHHS contracts with three Coordinated and Integrated Care Organizations (CICOs) to provide services for the dual eligible Medicare/Medicaid population in SC. Those organizations include First Choice VIP Care Plus by Select Health of SC (Select Health) Molina Healthcare of SC (Molina) and Wellcare Prime by Absolute Total Care (Wellcare). For this contract year, CCME completed an External Quality Review of Select Health and Wellcare. The EQR for Molina was postponed and will be completed and reported in the 2023 – 2024 Annual Technical Report.

This review focused on network adequacy for home and community-based services (HCBS) providers and behavioral health providers, over- and under-utilization, and care transitions. The process used by CCME for the EQR activities is based on the CMS *Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations*. To conduct the review, CCME requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over and under-utilization data, and care transition files.

Standards were scored as meeting all requirements ("Met"), acceptable but needing improvement ("Partially Met"), or failing a standard ("Not Met"). An overview of the findings for each section follows. The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) indicates the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate there was no change in the score from the previous review.

### *Provider Network Adequacy*

The CICOs are required by contract to maintain a network of Home and Community Based Service (HCBS) providers that is sufficient to provide all enrollees with access to a full range of covered services in each geographic area. The CICOs are also required to have a network of Behavioral Health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard.

SCDHHS established minimums for HCBS of at least two providers for each service in each county except Anderson, Charleston, Florence, Greenville, Richland, and Spartanburg counties. For these larger counties, the minimum was established as three providers for each service. The minimum number of required providers for each active county was calculated and compared to the number of current providers for seven different services:

- Adult Day Health
- Case Management

- Home Delivered Meals
- Personal Care
- Personal Emergency Response System (PERS)
- Respite
- Telemonitoring

CCME requested a complete list of all contracted HCBS providers currently in Select Health's and Wellcare's networks. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. For Select Health, 42 counties were documented as having members, with one member in a county labeled as "Other." Of the 294 services across 42 counties, 294 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%.

Wellcare documented having members in 46 counties. The HCBS adequacy rate for this year was calculated as 99.7% (321 service minimums out of 322 services were met). Aiken county only had one unique Adult Day Health provider contracted. The minimum number required for Aiken County is two. CCME recommended that Wellcare recruit additional Adult Day Health providers who can serve members in Aiken County.

*Table 51: HCBS Provider Adequacy Results* provides an overview of the network adequacy results for each CICO.

**Table 51: HCBS Provider Adequacy Results**

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Abbeville | | | |
| Adult Day Health | 2 | 2 | 4 |
| Case Management | 2 | 14 | 3 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 14 | 16 |
| Personal Care | 2 | 41 | 24 |
| Respite | 2 | 10 | 8 |
| Telemonitoring | 2 | 3 | 3 |
| Aiken | | | |
| Adult Day Health | 2 | 6 | 1 |
| Case Management | 2 | 12 | 6 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 46 | 20 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Respite | 2 | 13 | 5 |
| Telemonitoring | 2 | 3 | 2 |
| Allendale | | | |
| Adult Day Health | 2 | 5 | 2 |
| Case Management | 2 | 12 | 5 |
| Home Delivered Meals | 2 | 4 | 2 |
| PERS | 2 | 13 | 15 |
| Personal Care | 2 | 37 | 14 |
| Respite | 2 | 11 | 5 |
| Telemonitoring | 2 | 4 | 3 |
| Anderson | | | |
| Adult Day Health | 3 | 7 | 4 |
| Case Management | 3 | 11 | 3 |
| Home Delivered Meals | 3 | 6 | 3 |
| PERS | 3 | 17 | 17 |
| Personal Care | 3 | 68 | 32 |
| Respite | 3 | 15 | 11 |
| Telemonitoring | 3 | 5 | 3 |
| Bamberg | | | |
| Adult Day Health | 2 | 7 | 4 |
| Case Management | 2 | 13 | 5 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 42 | 17 |
| Respite | 2 | 11 | 5 |
| Telemonitoring | 2 | 4 | 4 |
| Barnwell | | | |
| Adult Day Health | 2 | 4 | 4 |
| Case Management | 2 | 11 | 5 |
| Home Delivered Meals | 2 | 4 | 4 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 40 | 18 |
| Respite | 2 | 11 | 5 |
| Telemonitoring | 2 | 4 | 4 |
| Beaufort | | | |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Adult Day Health | 2 | 4 | 3 |
| Case Management | 2 | 11 | 4 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 34 | 16 |
| Respite | 2 | 13 | 5 |
| Telemonitoring | 2 | 3 | 4 |
| Berkeley | | | |
| Adult Day Health | 2 | 6 | 4 |
| Case Management | 2 | 12 | 6 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 45 | 19 |
| Respite | 2 | 15 | 5 |
| Telemonitoring | 2 | 5 | 4 |
| Calhoun | | | |
| Adult Day Health | 2 | 10 | 5 |
| Case Management | 2 | 12 | 4 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 46 | 19 |
| Respite | 2 | 13 | 4 |
| Telemonitoring | 2 | 4 | 4 |
| Charleston | | | |
| Adult Day Health | 3 | 7 | 6 |
| Case Management | 3 | 12 | 6 |
| Home Delivered Meals | 3 | 6 | 4 |
| PERS | 3 | 13 | 16 |
| Personal Care | 3 | 49 | 22 |
| Respite | 3 | 15 | 8 |
| Telemonitoring | 3 | 5 | 4 |
| Cherokee | | | |
| Adult Day Health | 2 | 5 | 3 |
| Case Management | 2 | 9 | 4 |
| Home Delivered Meals | 2 | 4 | 2 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| PERS | 2 | 15 | 16 |
| Personal Care | 2 | 41 | 18 |
| Respite | 2 | 12 | 6 |
| Telemonitoring | 2 | 5 | 4 |
| Chester | | | |
| Adult Day Health | 2 | 8 | 6 |
| Case Management | 2 | 9 | 3 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 14 | 16 |
| Personal Care | 2 | 48 | 23 |
| Respite | 2 | 16 | 10 |
| Telemonitoring | 2 | 3 | 3 |
| Chesterfield | | | |
| Adult Day Health | 2 | 5 | 2 |
| Case Management | 2 | 11 | 3 |
| Home Delivered Meals | 2 | 5 | 5 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 43 | 18 |
| Respite | 2 | 16 | 6 |
| Telemonitoring | 2 | 3 | 3 |
| Clarendon | | | |
| Adult Day Health | 2 | 5 | 4 |
| Case Management | 2 | 15 | 6 |
| Home Delivered Meals | 2 | 6 | 3 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 54 | 18 |
| Respite | 2 | 15 | 6 |
| Telemonitoring | 2 | 3 | 3 |
| Colleton | | | |
| Adult Day Health | 2 | 6 | 5 |
| Case Management | 2 | 11 | 5 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 35 | 19 |
| Respite | 2 | 12 | 7 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Telemonitoring | 2 | 4 | 4 |
| Darlington | | | |
| Adult Day Health | 2 | N/A | 2 |
| Case Management | 2 | | 5 |
| Home Delivered Meals | 2 | | 2 |
| PERS | 2 | | 16 |
| Personal Care | 2 | | 21 |
| Respite | 2 | | 6 |
| Telemonitoring | 2 | | 2 |
| Dillon | | | |
| Adult Day Health | 2 | 5 | 2 |
| Case Management | 2 | 12 | 4 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 13 | 19 |
| Personal Care | 2 | 47 | 17 |
| Respite | 2 | 14 | 5 |
| Telemonitoring | 2 | 3 | 3 |
| Dorchester | | | |
| Adult Day Health | 2 | 7 | 3 |
| Case Management | 2 | 12 | 5 |
| Home Delivered Meals | 2 | 5 | 2 |
| PERS | 2 | 13 | 15 |
| Personal Care | 2 | 41 | 20 |
| Respite | 2 | 14 | 8 |
| Telemonitoring | 2 | 5 | 3 |
| Edgefield | | | |
| Adult Day Health | 2 | 3 | 3 |
| Case Management | 2 | 13 | 3 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 14 | 16 |
| Personal Care | 2 | 40 | 16 |
| Respite | 2 | 11 | 6 |
| Telemonitoring | 2 | 3 | 2 |
| Fairfield | | | |
| Adult Day Health | 2 | 8 | 5 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Case Management | 2 | 14 | 4 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 53 | 27 |
| Respite | 2 | 14 | 9 |
| Telemonitoring | 2 | 3 | 3 |
| Florence | | | |
| Adult Day Health | 3 | 6 | 3 |
| Case Management | 3 | 15 | 5 |
| Home Delivered Meals | 3 | 5 | 4 |
| PERS | 3 | 13 | 19 |
| Personal Care | 3 | 59 | 24 |
| Respite | 3 | 16 | 6 |
| Telemonitoring | 3 | 3 | 3 |
| Georgetown | | | |
| Adult Day Health | 2 | 7 | 4 |
| Case Management | 2 | 13 | 6 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 54 | 20 |
| Respite | 2 | 14 | 6 |
| Telemonitoring | 2 | 3 | 3 |
| Greenville | | | |
| Adult Day Health | 3 | 8 | 5 |
| Case Management | 3 | 16 | 4 |
| Home Delivered Meals | 3 | 6 | 4 |
| PERS | 3 | 17 | 18 |
| Personal Care | 3 | 77 | 33 |
| Respite | 3 | 15 | 13 |
| Telemonitoring | 3 | 5 | 5 |
| Greenwood | | | |
| Adult Day Health | 2 | 2 | 4 |
| Case Management | 2 | 14 | 6 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 14 | 16 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Personal Care | 2 | 53 | 26 |
| Respite | 2 | 13 | 10 |
| Telemonitoring | 2 | 3 | 2 |
| Hampton | | | |
| Adult Day Health | 2 | 4 | 3 |
| Case Management | 2 | 11 | 5 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 30 | 14 |
| Respite | 2 | 11 | 4 |
| Telemonitoring | 2 | 4 | 4 |
| Horry | | | |
| Adult Day Health | 2 | N/A | 3 |
| Case Management | 2 | | 7 |
| Home Delivered Meals | 2 | | 2 |
| PERS | 2 | | 17 |
| Personal Care | 2 | | 19 |
| Respite | 2 | | 5 |
| Telemonitoring | 2 | | 2 |
| Jasper | | | |
| Adult Day Health | 2 | 4 | 3 |
| Case Management | 2 | 11 | 4 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 13 | 16 |
| Personal Care | 2 | 29 | 16 |
| Respite | 2 | 11 | 6 |
| Telemonitoring | 2 | 3 | 4 |
| Kershaw | | | |
| Adult Day Health | 2 | 12 | 5 |
| Case Management | 2 | 14 | 5 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 13 | 18 |
| Personal Care | 2 | 57 | 28 |
| Respite | 2 | 16 | 11 |
| Telemonitoring | 2 | 3 | 3 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Lancaster | | | |
| Adult Day Health | 2 | N/A | 3 |
| Case Management | 2 | | 3 |
| Home Delivered Meals | 2 | | 2 |
| PERS | 2 | | 15 |
| Personal Care | 2 | | 22 |
| Respite | 2 | | 12 |
| Telemonitoring | 2 | | 2 |
| Laurens | | | |
| Adult Day Health | 2 | 2 | 4 |
| Case Management | 2 | 14 | 6 |
| Home Delivered Meals | 2 | 6 | 4 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 67 | 33 |
| Respite | 2 | 15 | 12 |
| Telemonitoring | 2 | 5 | 4 |
| Lee | | | |
| Adult Day Health | 2 | 5 | 5 |
| Case Management | 2 | 14 | 5 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 46 | 17 |
| Respite | 2 | 14 | 12 |
| Telemonitoring | 2 | 3 | 3 |
| Lexington | | | |
| Adult Day Health | 2 | 9 | 7 |
| Case Management | 2 | 17 | 6 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 72 | 35 |
| Respite | 2 | 15 | 10 |
| Telemonitoring | 2 | 4 | 4 |
| Marion | | | |
| Adult Day Health | 2 | 4 | 3 |
| Case Management | 2 | 13 | 6 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 14 | 18 |
| Personal Care | 2 | 52 | 22 |
| Respite | 2 | 14 | 5 |
| Telemonitoring | 2 | 3 | 3 |
| Marlboro | | | |
| Adult Day Health | 2 | 4 | 2 |
| Case Management | 2 | 8 | 3 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 41 | 19 |
| Respite | 2 | 13 | 6 |
| Telemonitoring | 2 | 3 | 3 |
| McCormick | | | |
| Adult Day Health | 2 | 2 | 3 |
| Case Management | 2 | 14 | 3 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 37 | 18 |
| Respite | 2 | 10 | 6 |
| Telemonitoring | 2 | 3 | 3 |
| Newberry | | | |
| Adult Day Health | 2 | 10 | 10 |
| Case Management | 2 | 14 | 6 |
| Home Delivered Meals | 2 | 6 | 5 |
| PERS | 2 | 14 | 17 |
| Personal Care | 2 | 54 | 27 |
| Respite | 2 | 13 | 8 |
| Telemonitoring | 2 | 3 | 3 |
| Oconee | | | |
| Adult Day Health Care | 2 | 4 | 2 |
| Case Management | 2 | 10 | 2 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 17 | 17 |
| Personal Care | 2 | 49 | 22 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Respite | 2 | 14 | 6 |
| Telemonitoring | 2 | 4 | 3 |
| Orangeburg | | | |
| Adult Day Health | 2 | 12 | 7 |
| Case Management | 2 | 14 | 7 |
| Home Delivered Meals | 2 | 5 | 3 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 62 | 25 |
| Respite | 2 | 14 | 9 |
| Telemonitoring | 2 | 4 | 4 |
| Pickens | | | |
| Adult Day Health | 2 | 4 | 3 |
| Case Management | 2 | 15 | 3 |
| Home Delivered Meals | 2 | 6 | 3 |
| PERS | 2 | 17 | 17 |
| Personal Care | 2 | 64 | 31 |
| Respite | 2 | 14 | 12 |
| Telemonitoring | 2 | 5 | 4 |
| Richland | | | |
| Adult Day Health | 3 | 12 | 8 |
| Case Management | 3 | 16 | 6 |
| Home Delivered Meals | 3 | 4 | 4 |
| PERS | 3 | 14 | 17 |
| Personal Care | 3 | 83 | 40 |
| Respite | 3 | 16 | 12 |
| Telemonitoring | 3 | 4 | 4 |
| Saluda | | | |
| Adult Day Health | 2 | 5 | 3 |
| Case Management | 2 | 15 | 3 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 48 | 23 |
| Respite | 2 | 11 | 7 |
| Telemonitoring | 2 | 3 | 3 |
| Spartanburg | | | |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| Adult Day Health | 3 | 6 | 6 |
| Case Management | 3 | 11 | 5 |
| Home Delivered Meals | 3 | 6 | 3 |
| PERS | 3 | 16 | 17 |
| Personal Care | 3 | 72 | 32 |
| Respite | 3 | 14 | 14 |
| Telemonitoring | 3 | 5 | 5 |
| Sumter | | | |
| Adult Day Health | 2 | 6 | 7 |
| Case Management | 2 | 16 | 6 |
| Home Delivered Meals | 2 | 7 | 3 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 61 | 24 |
| Respite | 2 | 15 | 9 |
| Telemonitoring | 2 | 3 | 2 |
| Union | | | |
| Adult Day Health | 2 | 8 | 7 |
| Case Management | 2 | 9 | 6 |
| Home Delivered Meals | 2 | 4 | 3 |
| PERS | 2 | 15 | 16 |
| Personal Care | 2 | 48 | 25 |
| Respite | 2 | 14 | 10 |
| Telemonitoring | 2 | 4 | 4 |
| Williamsburg | | | |
| Adult Day Health | 2 | 7 | 4 |
| Case Management | 2 | 16 | 7 |
| Home Delivered Meals | 2 | 5 | 4 |
| PERS | 2 | 13 | 17 |
| Personal Care | 2 | 49 | 19 |
| Respite | 2 | 14 | 6 |
| Telemonitoring | 2 | 3 | 3 |
| York | | | |
| Adult Day Health | 2 | N/A | 5 |
| Case Management | 2 | | 3 |
| Home Delivered Meals | 2 | | 2 |

| County | Minimum Required | Select Health Unique Providers | Wellcare Unique Providers |
|---|---|---|---|
| PERS | 2 | | 15 |
| Personal Care | 2 | | 23 |
| Respite | 2 | | 12 |
| Telemonitoring | 2 | | 2 |
| Total that Met Minimum (Sum of all services across the total number of counties with minimum required providers met) | | 294 | 321 |
| Total Required (Sum all of services across the total number of counties) | | 294 | 322 |
| Percentage MET | | 100% | 99.7% |
| VALIDATION DECISION | | Met | MET |

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

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

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

**Wellcare:** The requirements as set forth by the State were compared to submitted information. The Quest Analytics' Geo Access Network Analysis report showed that 99.9% had access to a psychiatrist; 99.4% had access to a psychologist; 100% had access to a social worker; and 99.9% had access to a CMHC. Wellcare met all network adequacy requirements for BH providers.

*Table 52: Provider Network Adequacy Comparative Data* provides an overview of each plan's score for the Provider Network Adequacy section.

**Table 52: Provider Network Adequacy Comparative Data**

| Standard | Select Health | Wellcare | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|
| Provider Network Adequacy | | | |
| The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services | Met | Met | **Strengths:**<br>▶ The CICOs maintained an adequate network sufficient to provide enrollees with access to a full range of Home and Community Based services in each geographic area. |
| The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services | Met | Met | |

### *Evaluation of Over- and Under-Utilization*

The CICOs are required to monitor and analyze utilization data to look for trends or issues that may provide opportunities for quality improvement. The over- and under-utilization monitoring focuses on five key indicators: 30-day hospital readmission rates for any potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services.

**Select Health** submitted several reports that addressed the over and under-utilization measures. The inpatient medical/surgical length of stay (LOS) was just below 10 days as of October 2021. The LOS for Skilled Nursing Facilities was just above 10 days as of the latest report. Other measures reported included:

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

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

**Wellcare** submitted reports on utilization in the five required services, as well as other services. Length of stay for hospitalizations declined from 11.5 to 11.2 in quarter three but was still above the expected rate of 6.5 days. The readmission rate increased from 12.4% in quarter one to 13.8% in quarter three. However, this rate remains below the target rate of 14.5%. The Behavioral Health service rate was at 2.2% in September 2022, which was a reduction from the January 2022 rate of 4.2%. The Skilled Nursing Facility length of stay rate showed an overall decline from 27 days in quarter one to 20 days in quarter four. Emergency room visits per 1000 increased in October (745) and November 2022 (744) relative to the September 2022 rate of 653 per 1000 enrollees. The reasons for the emergency room visits were not reported in the trending report. CCME found no issues with Wellcare's evaluation of their over- and under-utilization reports.

The CICOs met the requirements for evaluating over- and under-utilization as shown in *Table 53: Evaluation of Over/Under Utilization Comparative Data*.

**Table 53: Evaluation of Over/Under Utilization Comparative Data**

| Standard | Select Health | Wellcare | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|
| Evaluation of Over/Under Utilization | | | |
| The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to:<br>30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers) | Met | Met | |
| Length of stay for hospitalizations | Met | Met | |
| Length of stay in nursing homes | Met | Met | |
| Emergency room utilization | Met | Met | |
| Number and percentage of enrollees receiving mental health services | Met | Met | |

## *Care Transitions*

CCME reviewed each CICO's program descriptions and policies related to care transitions. The CICOs were also required to submit a file of enrollees who were hospitalized in an

acute care setting, discharged, and readmitted to an acute care facility within 30 days. The CICOs were directed to only include those enrollees readmitted with a diagnosis that met the definition of a potentially avoidable hospitalization. These were defined by SCDHHS as: Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers. Based on the file received from each CICO, CCME requested a random sample of files for review. An overview of the findings for Care Transitions follows.

**Select Health:** Transition of Care (TOC) services and activities were described in the Integrated Care Management Program Description and in policies. There were no issues identified with these documents.

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

Issues were noted in the files reviewed, including:

- Some files reflected no attempts to contact the facility's Case Management/Discharge Planning staff to collaborate in discharge planning.
- Some files did not provide evidence of any collaboration with the PCP when the member was admitted or discharged.
- Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done. This is a repeat finding from the previous EQR. See *Table 54: Previous Care Transitions Quality Improvement Items – Select Health* for the 2021 EQR findings and Select Health's response to the Quality Improvement Plan. Similar findings were also noted in the 2020 and 2021 EQRs.

**Table 54: Previous Care Transitions Quality Improvement Items – Select Health**

| Standard | EQR Comments |
|---|---|
| **III. Care Transitions** | |
| 1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions. | Transition of care (TOC) services and functions are defined and described in the Integrated Care Management Program Description and policies such as CM 156.209, Comprehensive Transitional Care, and CM 156.201, Comprehensive Care Management & Care Coordination.<br>CCME conducted a file review for members who were readmitted within 30 days of discharge from a hospital. Files revealed that |

| Standard | EQR Comments |
|---|---|
| | transition planning activities began when staff received notification of the member's admission or discharge. The assigned Care Coordinators, Care Connectors, and Community Health Navigators assisted with facilitating various TOC activities such as following up with family members, outreach to facility staff, making reminder phone calls, contacting pharmacies, and contacting providers when needed.<br>CCME identified documentation of TOC functions in majority of the files reviewed, such as:<br>•Consistently faxed communication with PCPs.<br>•Timely communication of admission and discharge notifications among staff.<br>•Contact and collaboration with case managers in facilities.<br>•Documentation of clinical follow-up phone calls within 72 hours.<br>•Medication monitoring.<br>However, the majority of files did not include documentation of a reassessment after a trigger event, such as a hospitalization or change in the member's status.<br>*Quality Improvement Plan: Ensure reassessments are performed according to requirements in SC CICO Three-Way Contract, Section 2.6.3.9.* |
| **Select Health Response:** On 8/2/21, the Select Health Population Health (Care Management) leader provided additional education to the CM team related to compliance with the CICO 3-Way Contract, Section 2.6.3.9. Specifically addressed were the need to document reassessments related to "trigger" events or change in member's health status (i.e., discharge from hospital to home, change in diagnosis, or change in caregiver support). The CM leader also provided an updated process for transition of care reassessments within the clinical documentation system (JIVA). Please see attached meeting minutes included as supportive evidence. The requirements of the CICO 3-Way Contract Section 2.6.3.9 have also been included in the Select Health, Population Health internal documentation audit process moving forward. | |

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

**Table 55: Care Transition Analysis Quality Improvement Items – Select Health**

| Standard | EQR Comments |
|---|---|
| **III. Care Transitions** | |

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

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

**Wellcare:** CCME reviewed care transitions files for a sample of members who were noted to have a readmission for specific diagnoses within 30 days of a previous discharge. Overall, the files reflected good documentation of supports needed by members after discharge, as well as barriers and interventions to address those barriers. The files also reflected attempts to obtain alternate contact information for members who were difficult to reach, letters to members notifying them of unsuccessful outreach attempts, and documentation of medication reconciliations.

Issues noted in the files included untimely attempts to contact members/caregivers within 72-hours of discharge for eight member files; lack of documentation of interaction with facility Case Managers or Discharge Planners for six files; and lack of documentation of collaboration with the PCP for three files. These are all repeat findings from the previous EQR. *Table 56: Previous Care Transitions Quality Improvement Items - Wellcare* displays the findings from the 2021 EQR and Wellcare's response.

**Table 56: Previous Care Transitions Quality Improvement Items - Wellcare**

| Standard | EQR Comments |
|---|---|
| **III. Care Transitions** | |
| 1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions. | The Healthy Connections Prime Care Management Program Description 2021 provides an overview of the program's purpose, scope, structure, goals, and objectives. Related policies, such as Policy SC.MMP.CM.24, Discharge Planning and Outreach, and SC.MMP.UM.02, Care Transitions, provide additional information and guide staff in conducting transition of care (TOC) activities for members transitioning between care settings.<br>CCME reviewed 36 files for members who were readmitted within 30 days of a hospital discharge and noted an overall improvement in the frequency of interdisciplinary care team meetings. The files reflected staff make multiple attempts to contact members after discharge, including attempting to get additional or alternate contact information from providers, facilities, etc. Overall, the files included documentation of clinical and non-clinical barriers and support.<br>Issues identified through the file review included:<br>•Lack of documentation of interaction with facility Case Managers or Discharge Planners was noted for six files.<br>•Lack of documentation of collaboration with the PCP was noted for seven files.<br>•Untimely – or no – attempts to contact members/caregivers within 72-hours of discharge in five files.<br>•Lack documentation of completion of a full assessment post discharge was noted for 13 files. It was noted that Policy SC.CM.24, Discharge Planning and Outreach – MMP, indicates "A subsequent HRA and ICT meeting is scheduled if hospitalization resulted from change in condition or functional status" and that if "admission resulted in minor changes in health condition" the Care Coordinator may update only applicable components of the health risk assessment specific to the condition in a clearly documented outreach note. However, the SC CICO Three-Way Contract, Section 2.6.3.9.4, requires the CICO to conduct a reassessment and ICP update upon any of the following trigger events: hospital admission, care setting transition, change in functional status, loss of caregiver, changes in or additions of a diagnosis, and if requested by the member of the multidisciplinary team. |

| Standard | EQR Comments |
|---|---|
| | Also, in some notes included in the files, the admission and discharge date fields were not completed, making it difficult to associate the note to a particular admission event.<br>*Quality Improvement Plan: Ensure files include thorough and complete documentation of all required activities, including collaboration with facility Case Managers or Discharge Planners, collaboration with the PCP, a post-discharge TOC assessment within 72-hours of discharge, and completion of a full assessment when there is a hospital admission or other care setting transition. Also, ensure the admission and discharge date fields are entered on case notes to allow the notes to be associated with an admission/transition event, where applicable.* |
| **Wellcare Response**: See Policy SC.CM.24 and Retraining | |

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

**Table 57: Care Transition Analysis Quality Improvement Items - Wellcare**

| Standard | EQR Comments |
|---|---|
| **III. Care Transitions** | |
| 2. Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes. | ATC tracks and monitors member transitions resulting in a higher level of care. During the period of December 2020 to November 2021, 1,225 MMP members experienced a transition of care. Of the 1,225 members, 154 (13%) transitioned to a higher level of care.<br>CCME could not identify documentation that ATC analyzed or reviewed the 154 transitions that resulted in a higher level of care to identify barriers or improvement opportunities, or any actions taken to improve outcomes.<br>Quality Improvement Plan: Develop and implement a process to analyze and review member transitions to a higher level of care to identify contributing factors and to implement actions to improve outcomes. |
| **Wellcare Response:** See Policy SC.CM.24 and Retraining | |

For this EQR, Wellcare submitted the 2022 Transition to Higher Level of Care Analysis that covered January through November 2022. Of the 1523 care transitions in 2022, 174 were to a higher level of care. This represented 11.4% of all transitions according to the

report. Specific events are researched in depth to identify barriers, problems, or opportunities to address those barriers. The results of this report are reported to the Utilization Management Committee.

CCME found issues with the file review for both CICOs. *Table 58: Care Transitions Comparative Data* shows Select Health received a "Not Met" score for the handing of care transitions. Wellcare's "Partially Met" score was due to their handling of care transitions.

**Table 58: Care Transitions Comparative Data**

| Standard | Select Health | Wellcare | ▶ = *Quality*<br>▶ = *Timeliness*<br>▶ = *Access to Care* |
|---|---|---|---|
| Care Transitions | | | |
| The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions | Not Met ↓ | Partially Met | **Strengths:**<br>▶ All the CICOs had policies and processes established to conduct appropriate transition of care (TOC) functions as required by the *SCDHHS Contract*.<br><br>**Weaknesses:**<br>▶ Select Health and Wellcare continue to have transition of care issues. Files lacked documentation of the required:<br>○ Collaboration with facility Case Management or Discharge Planning staff. (Select Health, Wellcare)<br>○ PCP notifications of admissions and discharges. (Select Health, Wellcare)<br>○ Attempts to contact members/care giver to compete assessments following discharge. (Wellcare)<br>○ Completions of reassessments following a trigger event. (Select Health)<br><br>**Recommendations:**<br>• Ensure all TOC functions required by the *SCDHHS Contract, Sections 2.5 and 2.6* are conducted and clearly documented in the members' files. |
| Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes | Met ↑ | Met ↑ | |

## FINDINGS SUMMARY

Overall, ATC and Select Health sustained or showed the most improvements in six areas. *Table 59: Annual Review Comparisons* reflects the total percentage of standards scored as "Met" for the 2021 through 2023 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings.

**Table 59: Annual Review Comparisons**

| | ATC | | Humana | | SELECT HEALTH | |
|---|---|---|---|---|---|---|
| | 2021 | 2022 | 2022 | 2023 | 2021 | 2022 |
| Administration | 100% | 100% | 95% | 88% | 100% | 100% |
| Provider Services | 97% | 99% | 85% | 96% | 96% | 97% |
| Member Services | 100% | 100% | 95% | 94% | 100% | 100% |
| Quality Improvement | 100% | 100% | 91% | 79% | 100% | 100% |
| Utilization Management | 98% | 100% | 86% | 91% | 100% | 96% |
| Delegation | 100% | 50% | 100% | 100% | 100% | 100% |
| State Mandated Services | 75% | 100% | 25% | 75% | 75% | 100% |

Regarding 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*, Select Health sustained or showed the most improvement in nine of the 10 categories. ATC and Humana sustained or showed improvements in eight of the 10 categories. *Table 60: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons* reflects the total percentage of standards scored as "Met" for the 2020 through 2023 EQRs. For the most recent reviews, the percentages with up arrow (↑) indicate improvement over the prior year's review findings. Those with a down arrow (↓) represent a reduction in the prior review findings.

**Table 60: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons**

| | | Availability of Services and Assurances of Adequate Capacity and Services | Coordination and Continuity of Care | Coverage and Authorization of Services | Provider Selection | Confidentiality | Grievance and Appeal Systems | Sub-contractual Relationships and Delegation | Practice Guidelines | Health Information Systems | Quality Assessment and Performance Improvement Program |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ATC | 2022 | 100% ↑ | 100% | 100% ↑ | 97% ↓ | 100% | 100% | 50%↓ | 100% | 100% | 100% |
| | 2021 | 75% | 100% | 92.8% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | 2020 | 87.5% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| *HUMANA | 2023 | 87.5% ↓ | 100% | 92.8% ↑ | 100%↑ | 100% | 90% | 100% | 100% | 100% | 79%↓ |
| | 2022 | *100% | 100% | 78.5% | 76.9% | 100% | 90% | 100% | 100% | 100% | **90.9% |
| SELECT HEALTH | 2022 | 75% | 100% | 100% | 100% | 100% | 90%↓ | 100% | 100% | 100% | 100% |
| | 2021 | 75% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| | 2020 | 75% | 87.5% | 100% | 94.8% | 100% | 100% | 50% | 100% | 100% | 100% |

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

**Humana's first EQR was in 2022. 2021 was a Readiness Review*

***The Standards Not Evaluated were removed from the denominator and numerator*