Constellation Quality Health

SELECT HEALTH OF SOUTH CAROLINA

2023 EXTERNAL QUALITY REIVEW

Submitted: October 20, 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 (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process for and results of the 2023 External Quality Review (EQR) that Constellation Quality Health, formerly The Carolinas Center for Medical Excellence (CCME), conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Select Health of South Carolina (Select Health) since the 2022 Annual Review.

The goals and objectives of the review are to:

- Determine if Select Health is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2022 annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

The process Constellation Quality Health used for the EQR is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO EQRs. The review includes a desk review of documents; a two-day virtual onsite visit; a Telephonic Provider Access Study; compliance review; and validation of performance improvement projects (PIPs), performance measures (PMs), network adequacy, and satisfaction surveys.

Summary and Overall Findings

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

- Disenrollment Requirements and Limitations (*§ 438.56*)
- Enrollee Rights Requirements *(§ 438.100*)
- Emergency and Post-Stabilization Services *(§ 438.114)*
- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*

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

To assess Select Health's compliance with the 14 Subpart D and QAPI standards as related to quality, timeliness, and access to care, Constellation Quality Health's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

Administration

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

Select Health has established processes for the development and ongoing management of policies and procedures, including annual policy review with revisions made as needed. The Policy and Procedure Subcommittee issues policy approvals, meets quarterly, and membership includes health plan leadership, directors, and managers. Select Health ensures staff have access to policies and are informed of new and revised policies.

Review of the Organizational Chart and Key Personnel List, along with onsite discussion, confirmed all required key positions are filled by appropriate personnel and staffing is sufficient. Recruitment activities are ongoing to fill vacant positions.

The 2022 Select Health of South Carolina Compliance Program document, the 2022 Program Integrity Plan, and related policies and procedures describe processes for maintaining compliance with contractual, state, and federal regulatory requirements and for monitoring, detecting, preventing, and investigating suspected or actual fraud, waste, and abuse. The Code of Conduct and Ethics communicates expectations for appropriate business behavior and conduct. Compliance training is required for all staff and is provided at employment and annually. The training covers pertinent topics and is reinforced with compliance tips and reminders that are sent via emails, intranet postings, and department-specific trainings. Annual Compliance Week activities includes activities to reinforce compliance as an integral element of daily business activities. Select Health provides various mechanisms for reporting potential noncompliance

issues, privacy and security concerns, and fraud, waste, and abuse allegations. Reports can be anonymous, and Select Health maintains open-door and no retaliation policies.

The Compliance & Privacy Committee is chaired by the Compliance Officer and includes executive and leadership staff. Minutes of the committee meetings reflected adequate attendance by voting members, the presence of a quorum for each meeting, and detailed discussions before decisions were made.

Select Health has established policies, procedures, and system capabilities to meet the requirements of the *SCDHHS Contract*. A detailed security plan establishes security goals that align with best practices and is bolstered with policies and procedures. Disaster recovery and business continuity plans ensure data and systems are operational in the event of an outage. Recent disaster recovery exercises validated the disaster recovery plan.

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 Credentialing Committee, with oversight from the Chief Medical Officer, sets standards for the Credentialing Program, determines if practitioners and organizational providers meet standards for network participation, and reports credentialing decisions to the Quality Assessment Performance Improvement (QAPI) Committee. Voting members include practitioners with a variety of specialties. Credentialing processes and requirements are detailed in the Credentialing Program 2023 document and in policies. Review of a sample of initial credentialing and recredentialing files revealed issues related to lack of documentation of admitting arrangements and failure to follow the process detailed in policy for verification of Clinical Laboratory Improvement Amendments certification.

Provider Directories include all required elements. Select Health uses a provider data management system and conducts monthly verifications of provider data as well as validations of the data through credentialing and recredentialing processes and annually auditing the online Provider Directory. However, for the provider access study conducted by Constellation Quality Health, the successful answer rate fell to 55% from last year's rate of 60%. Most of the unsuccessful calls were because the physician was no longer active at the location. Compliance rates for routine and urgent appointments were 35% and 65% respectively.

Processes for initial and ongoing provider education are found in policy. Initial and ongoing provider education activities are conducted to ensure providers can function effectively within the network. A variety of methods are used to conduct provider education, including face-to-face visits, letters, mailings, Provider Manual updates, newsletters, etc.

Network Adequacy Validation: A validation review of Select Health's provider network following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the MCO is meeting network standards defined by the State. Overall, Select Health met the requirements of the Network Adequacy Validation. The results of the Telephone Access Study conducted by Constellation Quality Health identified a weakness regarding the provider contact information and the availability of a routine appointment.

Geographic access standards for primary care providers (PCPs), specialists, and hospitals are defined in policies and are compliant with contractual requirements. Select Health monitors the geographic adequacy of the network by running quarterly geographic access reports and conducting an annual formal evaluation, which also considers member experience with network access and appeal data related to network adequacy. Although the geographic access reports dated January 12, 2023, reflect use of appropriate parameters for assessing geographic adequacy, incorrect standards were noted in the Annual Network Development Plan.

Select Health conducts annual call studies to assess provider compliance with appointment access standards and also monitors grievances, appeals, and CAHPS survey results related to appointment access. Action is taken to address any identified issues. As with geographic access standards, incorrect appointment access standards were noted in the 2022 Network Development Plan.

Overall, the methods used to assess network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software.

Member Services

42 CFR § 438.56, 42 CFR § 438.100, 42 CFR § 438.206(c), 457.1230(a) 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Member rights and responsibilities are documented in the health plan's policy as well as in the Member Handbook and Provider Manual, and members are informed of their rights in various ways. Select Health provides a new member packet that includes pertinent information for a newly enrolled member to understand health plan processes and requirements, how to request additional information, and provides contact information for questions.

The Member Handbook is available on the website and upon request and is a comprehensive resource for members to understand covered and excluded benefits, benefit limitations, processes for obtaining prior authorization when required, etc. One core benefit, non-hospital based rehabilitative therapies for children, was not addressed in the Member Handbook. The health plan's website is an additional resource for members and includes information such as the

Copayment Reference Guide. The Member Services Call Center is available during contractually required hours, and the Nurse Call Line is available around the clock.

The Member Handbook stresses the importance of routine and preventive care and provides information about specific care and disease management programs that are available. Select Health reminds members about recommended services and includes information about Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) services in the Member Handbook. Member-specific information may be viewed by logging into the secure Member Portal.

Select Health has established appropriate processes for notifying members of changes in services, benefits, and the provider network. Processes are also in place for ensuring member materials are produced in a manner to ensure member understanding by using an appropriate reading level and offering materials in alternate languages and formats. No-cost interpreter and translation services are also provided.

Members are educated about requirements for voluntary disenrollment via the Member Handbook, which also addresses circumstances under which a member may be involuntarily disenrolled. Members are instructed to contact Member Services or Healthy Connections Choices for more information. Contact information is provided.

For the adult and child member satisfaction surveys, Select Health contracts with Press Ganey, a certified vendor who acquired SPH Analytics. The adult response rate was 13.2%, a slight decline from last year's response rate of 13.4%. Improvement was noted in Rating of Health Plan, Getting Care Quickly, and Rating of Personal Doctor. The largest decline was in the Rating of Specialist. The child response rate was 16.7%, an increase over last year's rate of 13.7%. Improvement occurred for Rating of Personal Doctor. The largest decline was in the Rating of Health Care. The Child with Chronic Conditions response rate was 16%, also an improvement over the previous year's rate of 12.8%. Getting Care Quickly, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist improved from the previous year. The largest decline for the CCC population was Customer Service.

Grievance policy MMS.100, Member Grievances and Appeals Process, outlines the processes for filing, processing, and resolving member complaints and grievances. Information is provided in the Member Handbook, Provider Manual, and on the website. Select Health defines a grievance as an expression of dissatisfaction about any matter other than an adverse benefit determination. The sequence for handing a grievance from receipt to resolution is detailed in policy MMS.100, Member Grievances and Appeals Process. The sample of grievance files reviewed for the 2023 EQR found that grievances were processed timely, logged, categorized, analyzed, and maintained in accordance with the Contract requirements.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Select Health provided the 2023 Quality Management Program Description for this EQR. This document was developed based on the health plan's 2022 performance and outcomes. The changes were outlined, and the goals and objectives were similar to the goals and objectives in 2022. The 2023 Quality Improvement Program Description was provided to the QAPI Committee and the Board of Directors for review and approval.

The QAPI Committee oversees Select Health's quality, utilization, and population health management activities. This committee reports to the health plan's Board of Directors. The committee charter outlines the committee's primary responsibilities. The Quality Clinical Care Committee (QCCC) is a subcommittee of the QAPI Committee. The committee charter indicates the QCCC provides direction and oversight of clinical quality and appeals, utilization management, behavioral health management, population health management, chronic care management, and the pharmacy programs. The Quality of Service Committee also reports to the QAPI Committee and is responsible for assuring the performance and quality improvement (QI) activities related to Select Health's services are reviewed, coordinated, and effective.

All committees met at regular intervals, except the QCCC. The QCCC's charter indicates this committee meets a minimum of three times per year. However, this committee only met once in 2022. Per Select Health, most of this committee's business was switched to the QAPI Committee due to the availability of the providers serving on the QCCC.

The evaluation of the effectiveness of the QI program is conducted annually. Select Health submitted the Quality Management Program Evaluation for calendar year 2022, which included the results of all the activities conducted in 2022. The analysis for each activity, identified barriers, and opportunities for improvements were included.

Performance Measure Validation: Select Health produces HEDIS rates using software from a National Committee for Quality Assurance (NCQA)-certified measure vendor. The PM validation found that Select Health was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS PMs for the current measure year (2022), the previous measure year (2021), and the change from 2021 to 2022 are reported in the QI section of this report. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial rate increases or decreases from 2021 to 2022. Rate changes shown in green indicate a substantial improvement (>10%), and rates shown in red indicate a substantial decline (>10%). Substantial changes in year-over-year trending were found in four measures.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: Total	15.68%	27.83%	12.15%
Substantial Decrease in Rate (>10% decrease)			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
Counseling for Nutrition	70.21%	59.32%	-10.89%
Counseling for Physical Activity	69.41%	57.06%	-12.35%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	70.83%	58.33%	-12.50%

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

For the 2023 review, two PIPs were submitted and validated. As noted in tables that follow, a summary of each PIP's status and interventions are included.

Table 2: Diabetes Outcomes Measures PIP

Diabetes Outcomes Measures	
The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8). The Diabetes Outcomes PIP showed a slight decline in the HBA1C measure (42.82% to 42.09%) and the Blood Pressure Control measure (63.02% to 61.31%).	
Previous Validation Score	Current Validation Score
91/91=100% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results
Interventions	
• Data sharing by direct EMR access • Year-round medical record review • Value based payment programs	• Member incentives • Provider education • Newsletters

Table 3: Well Care Visit for the Foster Care Population PIP

Well Care Visits for the Foster Care Population	
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, even though 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. For this PIP, there are several rates monitored. Those rates included three retired HEDIS measures and several active measures. The retired measures showed a decline in the Adolescent Well Care rate (69.59% to 66.75%) and the Well Child in the First 15 months (6+ visits) (58.16% to 54.93%). The Well Child Visits in 3rd, 4th ,5th, and 6th years of life increased from 83.38% to 83.68%. For the active measures, the W30 measure (Well Child Visits in the First 30 months of life (0 – 15 months) declined 58.16% to 54.93%. The W30 measure for the 15-30 months declined from 89.33% to 87.01%. The Well Child Visit for the for 3-11 years declined from 77.42% to 76.30%, for 12- 17 years declined 76.02% to 72.22%. For ages 18-21, the measure improved 38.46% to 43.54%. The Total Well Child Visit rate declined 73.51% to 71.47%.	
Previous Validation Score	Current Validation Score
91/91=100% High Confidence in Reported Results	84/85=99% 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 • A texting campaign • The Take Flight Program • Member incentives

The performance improvement projects showed declines in some of the indicator rates. Constellation Quality Health recommended Select Health continue to assess the PIP interventions and the impact of each intervention wherein possible and consider conducting a sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.

Utilization Management

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

The review of Select Health's Utilization Management (UM) Program included program descriptions, relevant policies, medical necessity determination processes, the Member Handbook, the Provider Manual, and a sample of approval, denial, appeal, and care management files.

Select Health's Utilization Management (UM) Program Description outlines the UM Program's scope and objectives for physical health and behavioral health services. PerformRx serves as the pharmacy benefit manager. The Medical Director provides overall clinical oversight of the UM Program, and the Behavioral Health Medical Director and Pharmacy Director provide oversight of their respective programs. Initial review determinations are made by licensed clinical staff utilizing approved clinical criteria. Quarterly and annually, Select Health conducts Inter-Rater Reliability (IRR) testing for physicians and non-physicians to measure clinical consistency of criteria application for reviewers. A review of the utilization decisions made by Select Health reflected that determinations were completed within the appropriate timeframe and according to contractual requirements.

Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made. There was no information regarding when the negative PDL changes were published on the website as required by contract.

Select Health's Policy UM.318S, Preferred Provider Program, outlines the health plan's Preferred Provider Program. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented that did not correspond with the described process outlined in Policy UM.318S, Preferred Provider Program.

The 2023 EQR of Select Health's appeal processes included review of the Program Description, policies, the Member Handbook, Provider Manual, and a sample of appeal files. The review of the sample of appeal files found issues with seven files regarding the acknowledgement letters and failure to notify a member when the timeframe for resolution was extended.

Select Health's Case Management and Care Management Programs consists of various core components that entail wellness and prevention, member safety management, member transitional care, and complex care management. Select Health provides integrated medical-behavioral health management based upon a Four Quadrant Clinical Integration Model. The members are referred for case management services through various sources. Select Health's care management files indicate care management activities are conducted as required.

Delegation

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

Select Health delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include credentialing, UM, and the nurse call line. Documentation of annual oversight was provided for all delegated entities. The annual oversight documentation included

any deficiencies found during the annual evaluation, recommendations for improvement, and corrective action as needed.

Mental Health Parity

Constellation Quality Health conducted a Mental Health Parity assessment to determine if Select Health met the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment was conducted as a two-step process. Step one involved assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assessed the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits. Overall, the assessment found the mental health benefits and services limitations are aligned with the medical/surgical benefits and service limitations. Select Health met the requirements for Mental Health Parity.

Constellation reviewed Select Health's supporting documents to assess both elements of NQTL Parity: Comparability and Stringency. Compliance with these two factors depends on a parity of process, policy, and practice. This review found Select Health's denial rate for Mental Health/Substance Use Disorder (MH/SUD) is higher than the rate for medical benefits. By examining appeal overturn rates between medical appeals and MH/SUD appeals, Constellation Quality Health can make an inference about stringency. If the appeal overturn rates are higher for MH/SUD, as they are for medical benefits, it could mean that criteria are applied more stringently. A deeper dive into the appeal data should be performed to assess administrative compared to medical necessity. Administrative necessity would indicate a discrepancy in comparability while medical necessity indicates a discrepancy in stringency.

Select Health's Behavioral Health network is robust. Any gaps are in rural areas where demand for services exceeds available practitioners. One way to assess network adequacy is to examine the demand for out-of-network services and how many adverse decisions were appealed.

Select Health has the tools, plans, and interventions to support the goal of Parity. The NQTL assessment found the mental health services comply with Parity requirements of comparability and stringency.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were four standards scored as "Partially Met." The following is a high-level summary of those deficiencies:

- The *SCDHHS Contract, Section 6.2.3.1.4* requires MCOs to "Provide a choice of at least 2 required contracted specialists and/or subspecialists who are accepting new patients within the geographic area." Select Health's process for ensuring compliance with this requirement was not addressed in policies. The geographic access report dated October 14, 2022, also did not provide an indication that Select Health ensures members have a choice of at least two required specialists/subspecialists within their geographic area.
- Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, defines appointment access requirements but does not include the contractual requirements for wait times for scheduled routine appointments with PCPs or appointment scheduling for walk-in patients with non-urgent needs.
- The Provider Manual stated that the receipt of an appeal is acknowledged in one business day, which was inconsistent with Policy MMS.100, Members Grievances and Appeals Process.
- The Expedited Appeal Request Denial letter template states that "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 onsite discussion and the health plan 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 include the language that a written appeal is required within thirty calendar days of a verbal request.
- In four appeal files, the notifications sent to the members included incorrect information:
  - The Acknowledgement Letters for three expedited appeal files incorrectly indicated that that the appeals would be resolved in thirty days as opposed to 72 hours.
  - In one file, the notice sent to the member incorrectly informed the member that the reasoning for closing the appeal was due to the member not submitting a written appeal after a verbal request.

During the current EQR, Constellation Quality Health assessed the degree to which Select Health implemented the actions to address these deficiencies and found all the deficiencies were addressed and the quality improvement plans were initiated.

Conclusions

Overall, Select Health met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Select Health's compliance scores specific to each of the 14 Subpart D and QAPI standards above.

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

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. C	1	1	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	2	2	100%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	12	11	92%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	13	93%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	41	41	100%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	19	95%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D	9	9	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	16	16	100%

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

As noted in the table above:

- For Availability of Services and Assurances of Adequate Capacity and Services, the success rate of 55% for the telephonic provider access study conducted by Constellation Quality Health declined from the previous year's rate of 60%.
- The negative PDL changes published on Select Health's website did not meet the *SCDHHS Contract* requirements.
- The appeals were not processed according to policy.

Table 5: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2022 review. For 2023, 214 out of 218 standards received a score of "Met." There were three standards scored as "Partially Met," and one standard received a "Not Met" score.

Table 5: Scoring Overview

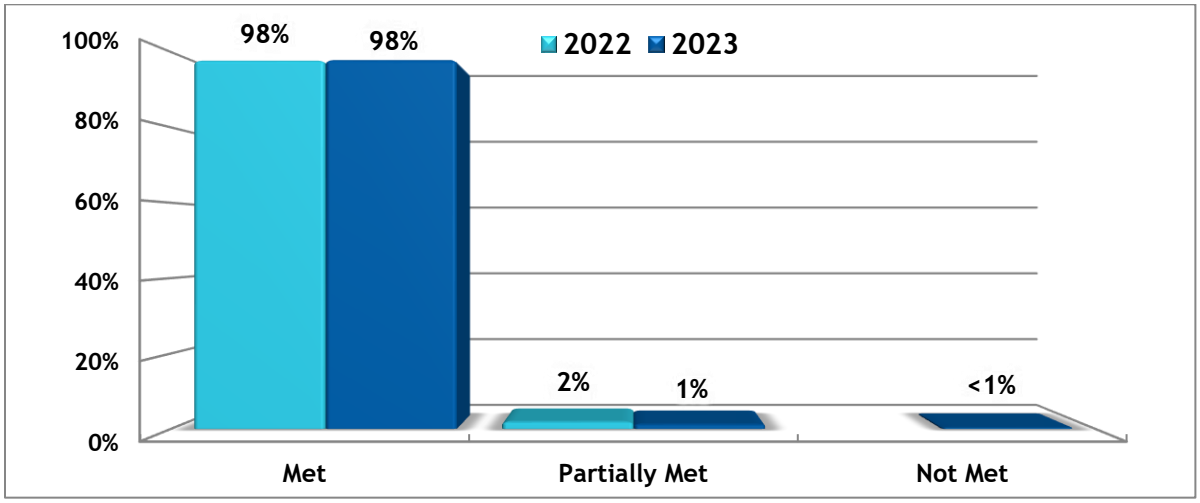
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	40	0	0	0	0	40	100%
2023	40	0	0	0	0	40	100%
Provider Services							
2022	74	2	0	0	0	76	97%
2023	79	0	1	0	0	80	99%
Member Services							
2022	33	0	0	0	0	33	100%
2023	33	0	0	0	0	33	100%
Quality Improvement							

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2022	14	0	0	0	0	14	100%
2023	16	0	0	0	0	16	100%
Utilization							
2022	43	2	0	0	0	45	96%
2023	42	3	0	0	0	45	93%
Delegation							
2022	2	0	0	0	0	2	100%
2023	2	0	0	0	0	2	100%
Mental Health Parity							
2023	2	0	0	0	0	2	100%
Totals							
2022	210	4	0	0	0	214	98.13%
2023	214	3	1	0	0	218	98.17%

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

The 2023 Annual EQR shows that Select Health achieved "Met" scores for 98% of the standards reviewed as the following chart indicates. This chart provides a comparison of the current review results to the 2022 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of Strengths, Weaknesses, and Recommendations can be found in the sections that follow.

Table 6: Quality, Timeliness, and Access to Care Strengths

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for initial policy development and ongoing policy review and management.	✓		
Overall staffing is adequate with all required key personnel positions filled, and recruitment efforts continuing to fill vacant positions.	✓		
For Information Systems, Select Health's recent risk assessment report demonstrates the organization has analyzed potential vulnerabilities/threats and understands where to focus security efforts.	✓		
Select Health has a robust disaster recovery plan which was recently tested and validated.	✓		
The Compliance Program, along with the Code of Conduct and Ethics and related policies, provide staff with detailed information about processes for ensuring compliance with laws and regulations, and provide guidance about appropriate business behavior and conduct.	✓		
The Program Integrity Plan and related policies and procedures thoroughly document processes to prevent, monitor for, detect, investigate, and respond to actual or suspected fraud, waste, and abuse.	✓		
The Pharmacy Lock-in Program meets all contractual requirements.			✓
Provider Services			
Credentialing and recredentialing processes are thoroughly documented in policies and the Credentialing Program Description.	✓		
The Credentialing Committee includes network providers with a variety of specialties, along with health plan management and staff.	✓		
Select Health's network is compliant with State-specified geographic access standards and includes all required Status 1 provider types.			✓
Various activities are conducted to ensure the provider network can serve members with special needs and those with cultural diversity.			✓
Provider education in accomplished through a variety of forums, and Select Health holds multiple regional provider education sessions yearly.	✓		
Member Services			
Members are informed of their rights and responsibilities in various ways, including outreach calls, the Member Handbook, newsletters, etc.	✓		

Strengths	Quality	Timeliness	Access to Care
Members are educated about benefits, services, health plan processes, etc. through the Member Handbook, the new member packet, etc. Member Services staff are available to answer member questions.	✓		
Appropriate processes are in place to inform members of changes in services, benefits, and the provider network.			✓
Member materials are written to ensure member understanding and are available in alternate languages and formats. Translation and interpreter services are provided at no cost.			✓
Processes for voluntary and involuntary disenrollment are compliant with contractual requirements.	✓		
A random sample of grievances reviewed for the 2023 EQR found that grievances were processed timely.		✓	
Quality Improvement			
Select Health has a number of ongoing interventions to track and improve well care visits.	✓		
The Performance Measures were compliant with the HEDIS technical specifications for rate calculations.	✓		
All Performance Improvement Projects received validation scores within the High Confidence range.	✓		
Utilization Management			
Select Health exceeded the target goal for Inter-Rater Reliability Testing with results of 96% or greater.	✓		
Approval notifications were provided to the member and provider the same day of the approval decision.		✓	
Denial files were completed in a timely manner and clearly described the reasoning for the adverse benefit decision according to contractual guidelines.		✓	
The 2022 SHSC Utilization Management Program Evaluation indicated that the turnaround time for behavioral and non-behavioral health appeals were all met in a timely manner.		✓	
Delegation			
All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process.	✓		
The annual oversight documentation included any deficiencies found during the annual evaluation, recommendations for improvement, and corrective action as needed.	✓		
Mental Health Parity			
Mental Health Parity assessment showed mental health services are aligned with medical surgical financial and treatment limitations.			✓
Access and availability parity is achieved; Provider Network analysis and implementation plans are robust and responsive down to the local level.			✓
Utilization Management Criteria and Processes achieve parity.			✓
IRR incorporates both MH/SUD and MS cases.			✓

Table 7: Weaknesses Recommendations and/or Quality Improvement Plans

Weaknesses	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Provider Services				
One initial credentialing file and one recredentialing file for nurse practitioners did not include admitting arrangements.	Recommendation: Ensure all credentialing and recredentialing files include admitting privileges or an established arrangement with another practitioner to admit on the applicant's behalf.			✓
One initial credentialing file reflected that Select Health did not follow the process specified in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing for verification of the provider's CLIA certificate.	Recommendation: Ensure verification of all documents within the required timeframes and following processes outlined in health plan policy.	✓		
Select Health's geographic access report dated January 12, 2023 reflects use of appropriate parameters for assessing geographic access to PCPs. It was noted that Select Health measures PCP access using a standard of 2 providers within 30 miles/45 minutes. However, page 18 of 243 of the Annual Network Development Plan states the geographic access distribution standard goal for PCPs is "1 Providers Within 30 miles ≥ 95%."	Recommendation: Revise the Annual Network Development Plan to list correct geographic access parameters for PCPs.			✓
Select Health's geographic access report dated January 12, 2023, reflects use of appropriate parameters for assessing geographic access to specialty providers. However, page 19 of 243 of the Annual Network Development Plan states the geographic access distribution standard goal is "1 specialist within 50 miles ≥ 95%" for all specialty categories.	Recommendation: Revise the Annual Network Development Plan lists to reflect the correct parameters for specialists.			✓
The 2022 Network Development Plan displays results of the 2022 appointment access study for primary care provider regular/routine and urgent care appointments; however, it lists the standard for routine new patient appointments as 10 business days. This is inconsistent with the timeframe specified in Policy NM 159.203 and the Provider Manual. It also lists the standard for routine, existing patient appointments of 10 business days, which is not stated in Policy NM 159.203 or the Provider Manual.	Recommendation: Correct the standard for routine new patient and routine existing patient appointments in the Select Health of South Carolina Accessibility of Services for Reporting Timeframe: 2022.			✓
For the Telephone Provider Access Study, conducted by Constellation, calls were successfully answered 55% of the time (107 out of 193) when omitting calls answered by personal or general voicemail messaging	Quality Improvement Plan: Continue current processes that are conducted to update and validate provider contact information. Look for additional ways to improve			✓

Weaknesses	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
services. The success rate declined from the previous year's rate of 60%. Routine appointments were available within the contract requirements (30 days) for 26 (35%) of the 74 providers that are accepting new patients. A total of 48 providers (65%) reported appointment availability outside of the required timeframe.	provider contact information, such as increasing the frequency of monitoring and verifying provider contact information. Also, reeducate all providers about required appointment access standards.			
Select Health's website includes a "Provider Training and Education" page that includes links for ongoing educational opportunities, Cultural Competency, HEDIS, and behavioral health topics. It was noted that the hyperlinks for two of the listed resources, DiversityRx and Polyglot Systems, were nonfunctional, returning error messages when attempting to access the information. This was mentioned during the previous EQR, and no action was taken to correct these hyperlinks.	Recommendation: Correct the non-functional links to DiversityRx and Polyglot Systems on the Select Health website.	✓		
Member Services				
Most core member benefits are covered in the Member Handbook; however, it does not address non-hospital based rehabilitative therapies for children, as required by the *SCDHHS Contract, Section 4.2.22*.	Recommendation: Ensure all core benefits are included in the benefits information in the Member Handbook.			✓
Quality Management				
The Quality Clinical Care Committee did not meet at regular intervals as required by the committee's charter.	Recommendation: Ensure the Quality Clinical Care Committee meets at regular intervals as outlined in the committee charter.	✓		
The performance improvement projects showed declines in indicator rates.	Recommendation: Continue to assess the PIP interventions and assess the impact of each intervention wherein possible. Also, consider conducting a sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.	✓		
Utilization Management				
Select Health's Policy UM.318S, Preferred Provider Program, outlines the health plan's Preferred Provider Program. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented that allow providers to override	Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the *SCDHHS Contract, Section 8.5.2.8* and outlined in Policy UM.318S, Preferred Provider Program.	✓		

Weaknesses	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
submitting authorizations and auto member enrollment for high performing primary care providers. The two described processes do not coincide with the described process as outlined in Policy UM.318S, Preferred Provider Program or contractual regulations.				
Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. There was no information regarding when the negative PDL changes were published on the website. The health plan's changes notices of the PDL changes on the website did not appear to be updated 30 days prior to the effective date as required by contractual regulations.	Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Select Health's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3*.	✓		
The sample of appeal files reviewed found issues with seven files regarding the acknowledgement letters and failure to notify a member when the timeframe for resolution was extended.	Quality Improvement Plan: Ensure that acknowledgement letters are sent to members in accordance with Policy MMS.100, Member Grievances and Appeals Process. Develop a process to monitor a sample of appeal files to ensure all the requirements for processing appeals are met. Conduct a root-cause analysis when deficiencies are found so interventions can be developed to address the deficiencies.		✓	
Mental Health Parity				
The analysis of denials and appeals was incomplete. While Z scores were displayed for MH/SUD and MS, Constellation was unable to determine the denominator used, and was thus unable to compare overturned appeals/K for MH/SUD and overturned appeals/K for MS. A further breakdown of administrative appeals vs. clinical appeals would help determine, if any problems are noted, whether the problem is with consistency or stringency.	Recommendation: Analyze the administrative and medical necessity appeals separately to tease out the root cause of any identified differences between MH/SUD and MS comparability and stringency. Expressing the rates per thousand will help with this.			✓

METHODOLOGY

The process Constellation Quality Health used for the EQR activities was based on protocols CMS developed for the EQR of a Medicaid MCO/PIHP and focuses on the four federally mandated EQR activities of compliance determination and validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On July 31, 2023, and August 4, 2023, Constellation Quality Health sent notification to Select Health that the Annual EQR was being initiated (see *Attachment 1*). These notifications included a list of materials required for a desk review and an invitation for a teleconference to allow Select Health to ask questions regarding the EQR process and the requested desk materials.

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

The second segment was a virtual onsite review conducted on September 20 and 21, 2023. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Select Health's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

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

A. Administration

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

The review of the Administration section encompasses policy development and management, staffing, information systems, compliance/program integrity, and confidentiality.

Select Health follows processes outlined in Policy SHC 168.001, Policy & Procedure Program Management & Format Guidelines, for the development and ongoing management of policies and procedures. These processes include an annual review of each policy with revisions made as needed to reflect changes in contractual requirements, laws, and regulations. The Policy and Procedure Subcommittee of the Compliance Committee issues policy approvals. This subcommittee meets at least quarterly, and voting members include the Market President, Director of Compliance, Market Chief Medical Officer, and other internal directors and managers. Policies are housed on a shared drive for staff access and are available on the company's intranet. New employees are responsible for reviewing policies during orientation, and policy updates are shared with all staff by departmental leadership.

Review of the Organizational Chart and Key Personnel List, along with onsite discussion, confirmed staffing is sufficient to ensure activities required by the *SCDHHS Contract* can be conducted. All required key positions are filled by appropriate personnel, and very few vacancies are noted across the organization. For vacant positions, recruitment and interviewing activities are ongoing.

The 2022 Select Health of South Carolina Compliance Program (Compliance Plan) and the 2022 Program Integrity Plan for Select Health of South Carolina (Program Integrity Plan) describe processes that have been established to maintain compliance with contractual, state, and federal regulatory requirements and to monitor, detect, prevent, and investigate suspected and actual fraud, waste, and abuse (FWA). Related policies and procedures provide detailed information about these topics. Select Health has established a Code of Conduct and Ethics to communicate the company's expectations for appropriate business behavior as well as consequences of noncompliance. The Code of Conduct and Ethics is provided to all employees at the time of hire and annually thereafter. In addition, staff can access the Code of Conduct and Ethics at any time on the company intranet and hard copies are available upon request.

The Compliance Plan addresses the role of the Compliance Officer in managing the Compliance Program as well as the role of the Program Integrity Department and Special Investigations Unit. The Compliance Plan also addresses processes for ensuring staff are educated about compliance and FWA. This training is required of all staff, the Board of Directors, contingent workforce members, etc. Compliance training is provided at employment (or appointment to the Board) and then annually, and includes a variety of topics such as False Claims Acts, Anti-Kickback Statutes, the Deficit Reduction Act, Fraud Enforcement and Recovery Act, Health Insurance Portability and

Accountability Act (HIPAA), etc. It also covers security awareness, conflicts of interest, the code of conduct, and disciplinary consequences of noncompliance. In addition to the required annual training, employees receive compliance tips and reminders through email alerts, intranet postings, and department-specific training. Of note, the Corporate Compliance Department organizes annual Compliance Week activities that help to reinforce compliance as an integral element of daily business activities.

Select Health provides various mechanisms for reporting potential noncompliance issues, privacy/security concerns, and alleged FWA. These mechanisms are available to staff, contingent workforce members, subcontractors, vendors, providers, and members and include the ability to make anonymous reports. Select Health disseminates information about reporting methods through educational materials and communications and posts the information throughout Select Health offices. In addition, open-door and no retaliation policies are maintained.

The Compliance & Privacy Committee serves in an oversight role to ensure the effectiveness of and to develop and set priorities for the Compliance & Privacy Program. The committee is chaired by the Compliance Officer, who has the tie-breaking vote, and additional voting membership includes MCO executive and leadership staff. Meetings are held at least quarterly, and a quorum is established with the presence of at least 50% of the voting members. Minutes of the committee meetings from September 28, 2022, through May 24, 2023, confirmed adequate attendance by voting members and the presence of a quorum for each meeting. The minutes reflected detailed discussions before decisions were made.

Information Management Systems Assessment

The Information Management Systems Assessment (ISCA) materials Select Health provided demonstrate the MCO has established policies, procedures, and system capabilities to meet the requirements of the *SCDHHS Contract*. Select Health has a detailed security plan that establishes security goals that align with best practices. Select Health's security plan is bolstered with policies and procedures that address the tasks necessary to maintain the security plan. Additionally, the MCO has a disaster recovery and business continuity plan to ensure its data and systems are operational in the event of an outage. Finally, Select Health's documentation included the results of a recent disaster recovery exercise which validated the disaster recovery plan.

As noted in *Figure 2: Administration Findings*, Select Health achieved scores of 100% for all standards in the Administration section of the EQR.

Figure 2: Administration Findings

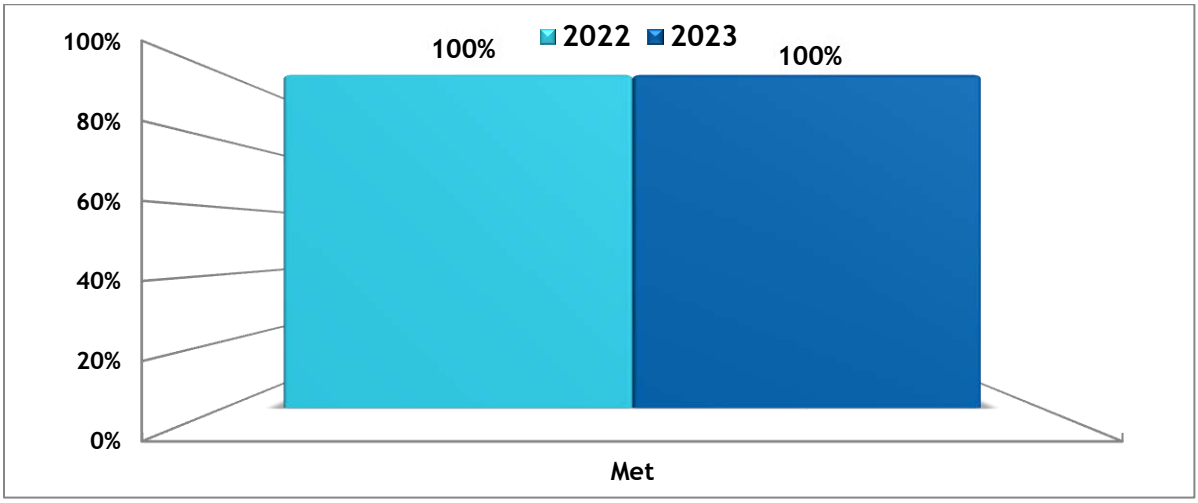


Table 8: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for initial policy development and ongoing policy review and management.	✓		
Overall staffing is adequate with all required key personnel positions filled, and recruitment efforts continuing to fill vacant positions.	✓		
For Information Systems, Select Health recently completed a risk assessment report which demonstrates the organization has analyzed potential vulnerabilities and threats and understands where to focus security efforts.	✓		
Select Health has a robust disaster recovery plan which was recently tested and validated.	✓		
The Compliance Program, along with the Code of Conduct and Ethics and related policies, provide staff with detailed information about processes for ensuring compliance with laws and regulations, and provide guidance about appropriate business behavior and conduct.	✓		
The Program Integrity Plan and related policies and procedures, thoroughly document processes to prevent, monitor for, detect, investigate, and respond to actual or suspected fraud, waste, and abuse.	✓		
The Pharmacy Lock-in Program meets all contractual requirements.			✓

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy SHC 168.001, Policy & Procedure Program Management & Format Guidelines, confirms policies are reviewed annually and updated as needed. Policy approvals are issued by the Policy and Procedure Subcommittee of the Compliance Committee. The Policy and Procedure Subcommittee meets at least quarterly with additional meetings if necessary. Voting members of the subcommittee include the plan's Market President, Director of Compliance, Market Chief Medical Officer, and other internal directors and managers. As noted in Policy SHC 168.001, final versions of policies are saved to a shared drive folder accessible by all staff and added to the company intranet. Newly hired staff are expected to read existing policies and procedures during their departmental orientation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Departmental leadership share policy updates with staff, and staff are expected to read new policies within a reasonable timeframe. Select Health archives revised and retired policies and retains them for 10 years.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Courtnay Thompson is the Market President. Sean Popson the Director of Plan Operations and Administration. Both are located in SC.
1.2 Chief Financial Officer (CFO);	X					Jan Fuller is Director Finance and serves as the Chief Financial Officer. She is located in SC.
1.3 * Contract Manager;	X					Erin Garian is the Contract Account Manager and is located in SC.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Philip Fairchild serves as the Claims Manager and Vee-Ping Mast serves as Encounters Manager.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4.2 Network Management Claims and Encounter Processing Staff,	X					As noted in the ISCA tool, claims processing is a corporate function. The following staff are involved in claim and encounter processing: Claim Examiners, Provider Claim Service Representatives, Research Analysts, and Encounter Analysts.
1.5 Utilization Management (Coordinator, Manager, Director);	X					Andrea Kilburn-Conyers is the Director, Market Clinical Population Health. She is a SC-licensed Registered Nurse. Multiple Utilization Management (UM) Review Managers and supervisors oversee UM staff.
1.5.1 Pharmacy Director,	X					Kelly Martin is the Director Pharmacy and is a licensed pharmacist in SC.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					Case Management staff are located in SC. Although the organizational chart reflected multiple vacancies, onsite discussion revealed that all current positions are filled except one. The other positions indicated as vacant are approved positions that are not yet needed.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Nathaniel Patterson is the Director Quality Improvement, and Alesia Boling is the Manager Quality Management. Both are located in SC.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Staff includes a Quality Performance Team Lead, Clinical Quality Performance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Specialists, Quality Performance Specialists, and Senior Community Health Navigators. No vacancies were noted.
1.7 *Provider Services Manager;	X					Peggy Vickery is the Director of Provider Network Management and serves as the Director of Provider Services. Philip Fairchild is the Director of Provider Network Operations.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Charles Ducharm is the Director of Member Services. The Manager of Member Services is Toni Parnell. She is located in SC.
1.8.1 Member Services Staff,	X					Member Services staff include the Member Services Supervisor, Contact Center Supervisors, Customer Service Representatives, a Senior Business Analyst, and Quality Coordinators. There are 16 vacancies noted for Customer Service Representatives noted on the Organizational Chart. Onsite discussion revealed these are approved positions that are not yet needed.
1.9 *Medical Director;	X					The Market Chief Medical Officer is Kirt Caton, MD, who is a SC licensed family practitioner.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional Medical Directors include: • Kathleen Domm, MD, a board certified, SC-licensed pediatrician who serves as Medical Director for Foster Care. • Michelle Cooke, a SC-licensed psychologist who serves as the Behavioral Health Medical Director.
1.10 *Compliance Officer;	X					Alejandro Mendizabal is the Director of Compliance and serves as the Compliance Officer.
1.10.1 *Program Integrity Coordinator;	X					Kim Miller is the Program Integrity Coordinator and is located in SC.
1.10.2 Compliance/ Program Integrity Staff;	X					
1.10.3 *Program Integrity FWA Investigative/Review Staff;	X					
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					
1.13 *Behavioral Health Director.	X					Dr. Cooke serves as the Behavioral Health Director.
2. Operational relationships of MCO staff are clearly delineated.	X					Reporting and operational relationships of staff are displayed on the Organizational Charts provided for review. During the onsite, noted vacancies were discussed and it was reported that recruitment and interview activities are ongoing to fill the positions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Select Health's documentation states the MCO's payment processing rate matches the percentages required by the *SCDHHS Contract*. Additionally, it was noted that if a claim is not paid in 30 days, supervisors reprioritize workloads across departments to ensure the claim is processed.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					An Electronic Data Interchange system is incorporated into Select Health's IT systems. Select Health notes, "EDI claim data receipt must conform to all HIPAA SNIP Level 5 compliance checks including the use of national standard code sets for HIPAA transactions." Finally, the MCO states that 837 and CM1500 formats are used for claims and encounter forms.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health's systems can track enrollees who switch from one product line to another, and track and link previous claim/encounter data across product lines. Additionally, the MCO's systems process 834 files daily, and if there is a discrepancy, procedures are in place to ensure a resolution is found within 24 hours.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality	X					Select Health uses Quality Spectrum Insight (QSI) to create all Medicaid reports. QSI is a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
improvement and utilization monitoring activities.						National Committee for Quality Assurance–certified HEDIS software. The MCO stated each transaction file is run through a comprehensive quality analysis process prior to being merged into the HEDIS data repository.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Select Health follows best practices in managing physical security and electronic data security. Access to facilities and computer systems is assigned in accordance with the principle of least privilege. Additionally, routine audits are performed to validate security controls.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					The materials provided by Select Health indicate the MCO adheres to information security and access management best practices. Select Health also provided its vulnerability management policy, which details how the MCO will mitigate and fix any security vulnerabilities found in its systems.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Select Health has a detailed disaster recovery plan for systems failover to a secondary data center in the case of a significant issue at the primary data center. The plan was tested on April 26th, 2023) and all applications and services were failed

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						over and validated in the secondary data center in six hours, 56 minutes.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Select Health submitted the 2022 Select Health of South Carolina Compliance Program (Compliance Plan) document as well as the 2022 Program Integrity Plan for Select Health of South Carolina (Program Integrity Plan). As noted in the Compliance Plan, the Compliance Program ensures the MCO maintains compliance with contractual, state, and federal regulatory requirements. In addition, the Program Integrity Department was established to monitor, detect, prevent, and investigate instances of suspected and actual fraud, waste, and abuse (FWA). In addition to the Compliance Plan and Program Integrity Plan, policies and procedures provide detailed information about the topics in the standards below.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Policy 168.102, Code of Conduct and Ethics and Disciplinary Action is a corporate policy that applies to all lines of business. The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy indicates standards of conduct have been established and are specified in the Code of Conduct and Ethics. The conduct standards are intended to communicate expectations for business behavior and conduct for all employees as well as consequences of non-compliance. The Code of Conduct and Ethics is provided to all employees at the time of hire and annually thereafter. In addition, staff can access the Code of Conduct and Ethics at any time on the company intranet, and hard copies are available upon request.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan addresses the roles of the Compliance Officer. The Compliance Officer manages the Compliance Program and reports to the Select Health Market President and to the Board of Directors as needed. The Compliance Plan also addresses the role of the Program Integrity Department and Special Investigations Unit (SIU). "SIU staff includes experienced investigators and analysts, including Certified Professional Coders, Registered Nurses, Certified Fraud Examiners, and Accredited HealthCare

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Fraud Investigators. The SIU has dedicated staff that supports Select Health." The Program Integrity Plan defines the role of the Program Integrity Coordinator as, "to coordinate FWA efforts with the SCDHHS Program Integrity and/or Division of Surveillance and Utilization Review."
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						The Compliance Plan Matrix includes organizational charts for Select Health, encounters/claims processing, legal, program integrity/SIU, and Corporate Compliance and Privacy.
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						The Compliance Plan addresses compliance training processes and topics. The training is required for members of the Board of Directors, all staff, contingent workforce, etc. Compliance training is provided at employment (or appointment to the Board) and then annually. The training includes information about Federal and State False Claims Acts, the Anti-Kickback Statute, Deficit Reduction Act, Fraud Enforcement and Recovery Act, Health Insurance Portability and Accountability Act, etc. It also covers compliance laws, whistleblower

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						protections, security awareness, conflicts of interest, and the code of conduct. In addition to the required annual training, employees receive compliance tips and reminders via: • Email alerts • Intranet postings • Department-specific trainings Corporate Compliance organizes and conducts an annual Compliance Week that showcases local Select Health activities and events.
2.6 Lines of communication;						Mechanisms for reporting potential noncompliance issues, privacy and security concerns, and alleged FWA are addressed in the Compliance Plan. These mechanisms include the ability to make anonymous reports by telephone and online and are available to staff, contingent workforce members, subcontractors, vendors, providers, and members. Separate websites are available for reporting compliance, privacy, and ethics concerns and FWA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Reporting mechanisms are posted publicly in Select Health offices and disseminated in educational materials and communications. An open-door policy is established for employee access to Compliance Department staff, and various email addresses are available for contacting staff in the following areas: Corporate Compliance, Health Plan Compliance, Privacy, and Fraud. In addition, Select Health escalates complaints received in grievances related to allegations of misconduct, privacy, compliance issues, and suspected FWA to the appropriate department for investigation, resolution, and reporting. Corporate Policy 168.103, Compliance Tools for Effective Lines of Communication, provides additional information for staff to understand the available communication options and procedures.
2.7 Enforcement and accessibility;						The Compliance Plan includes information about enforcement of standards through disciplinary guidelines. The guidelines are provided to staff at employment and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						annually through training programs and materials and are available on the intranet. Policy 168.102, Code of Conduct and Ethics and Disciplinary Action, states that failure to comply with the Code of Conduct may result in disciplinary action, including termination of employment. Policy 115.600, Progressive Discipline Policy, details processes for addressing noncompliance with policies, procedures, and performance and conduct expectations.
2.8 Internal monitoring and auditing;						As noted in the Compliance Plan, "Routine monitoring and auditing activities include both initial testing for compliance metrics and validation reviews to confirm ongoing compliance and appropriate resolution of remediation and corrective actions." These activities include: • Annual risk review—to identify areas of potential risk. Results are used to identify, develop, and implement oversight activities to be included in the Compliance and Privacy Work plan. • Routine monitoring and auditing to assist with validating and ensuring

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						compliance with contractual and other regulatory requirements through desk audits, on-site audits, data analysis, and statistical sampling. • Program integrity monitoring using auditing tools to detect and mitigate FWA.
2.9 Response to offenses and corrective action;						Responses to identified noncompliance may include internal and external warning letters, internal remediation and corrective action initiatives, investigation protocols for FWA, and reporting as required and applicable to regulatory agencies. The Compliance Department tracks the status of remediation and corrective actions and reports the activities to the Select Health Compliance Committee.
2.10 Data mining, analysis, and reporting;						As noted in the Program Integrity Plan, the Program Integrity Department, through internal resources and external vendors, conducts pre-payment claims edits and retrospective data mining. All claims go through multiple rounds of analysis. The Claims Cost Management team data mines for claim overpayments in a pre-payment status and retrospective data mining activities focus on recovery when the following are identified: outpatient charges

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						billed during inpatient stay; payments greater than billed charges; duplicate claims; and incorrect benefit payment coordination. Additional information about these processes is found in Policy 106.600.003, Internal Prospective Data Mining, and Policy 106.200.003, Vendor Retrospective Overpayments and Recoveries – Data Mining.
2.11 Exclusion status monitoring.						The Compliance Plan addresses proactively validating a provider's eligibility to participate in federal and state health care programs by conducting monthly monitoring for sanctions and exclusions. In addition, exclusion monitoring is conducted for all staff, contingent workforce members, subcontractors, and vendors.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance & Privacy Committee Charter defines the committee's purpose as assisting the Director of Compliance with implementing and overseeing the Compliance & Privacy Program. The committee also serves in an oversight role to ensure the effectiveness of and to develop and set priorities for the Compliance & Privacy Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Compliance & Privacy Committee is chaired by the Compliance Officer, who has the tie-breaking vote. Additional voting membership includes MCO executive and leadership staff. Meetings are held at least quarterly, and a quorum is established with the presence of at least 50% of the voting members. Minutes of the committee meetings from September 28, 2022, through May 24, 2023, confirmed adequate attendance by voting members and the presence of a quorum for each meeting. The minutes reflected detailed discussions before decisions were made.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Policy 168.104, Compliance Investigations, Inquiries and Non-retaliation Policy, describes processes for conducting investigations of compliance issues, alleged misconduct, etc. At the conclusion of investigations, disclosure will be provided to law enforcement and/or state and federal regulatory agencies if determined to be relevant and appropriate.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy 106.100.008, Fraud and Abuse Investigations, describes processes for conducting investigations of potential fraud and abuse activities. The policy states the SIU collaborates and cooperates with local, state, and federal law enforcement agencies, state insurance fraud departments, state Medicaid Fraud Control Units, and state Medicaid Program Integrity Units in cases of fraud.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy 106.400.001, Recovery Project Submission and Processing, and Policy 106.100.015, Subject: Provider Payment Suspension, detail processes for suspending provider payments and recouping overpayments.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					

B. Provider Services

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

The review of Provider Services includes credentialing and recredentialing processes, network adequacy, provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical records.

Provider Credentialing and Selection

The Board of Directors delegates oversight of the Credentialing Program to the Quality Assessment Performance Improvement (QAPI) Committee. The Credentialing Committee is a subcommittee of the QAPI Committee, and responsibilities include, but are not limited to, setting standards for the Credentialing Program; determining if practitioners and organizational providers meet standards for network participation; and reporting credentialing decisions to the QAPI Committee.

Select Health's Chief Medical Officer oversees the Credentialing Committee, provides clinical oversight of credentialing activities, and can make determinations for clean credentialing and recredentialing files. The Credentialing Committee's voting membership includes practitioners with a variety of specialties including family practice/family medicine, psychology, pediatrics, internal medicine, obstetrics and gynecology, and surgery. Review of Credentialing Committee minutes for August 24, 2022, though June 21, 2023, reflected the presence of a quorum for each meeting and revealed no issues with member attendance.

The written Credentialing Program 2023 (Credentialing Program Description) provides an overview of the scope, goals, structure, and criteria for Select Health's credentialing processes and program. Detailed information about requirements for initial credentialing and recredentialing is found in related policies. A sample of initial credentialing and recredentialing files for practitioners and organizational providers was reviewed to determine compliance with requirements. It was found that one initial credentialing file for a nurse practitioner and one recredentialing file for a nurse practitioner did not include admitting arrangements. Select Health responded that the admitting arrangements are addressed in the Nurse Practitioner Collaborative Agreements within the files. However, review of the collaborative agreements confirmed they did not address arrangements or a plan for admitting patients. For one file, the CLIA verification was dated March 1, 2022, and the approval of network

participation was issued on December 9, 2002. It appears that Select Health did not follow the process outlined in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, for CLIA verification. No issues were noted in the initial credentialing and recredentialing files for organizational providers.

Select Health conducts initial and monthly checks of licensing boards and required databases to identify any providers who may be excluded from participating in Federal health care programs. Initial checks are conducted by health plan staff, and ongoing monitoring is conducted by Provider Trust. Any potential matches are reported to applicable internal departments, and providers may be referred to the Credentialing Committee for discussion and determination of appropriate intervention. Additionally, Select Health conducts ongoing monitoring for and investigates any potential quality of care and service concerns and refers providers to the Credentialing Committee, when applicable, for further review and possible action, which may include panel restriction, suspension, or termination from the network.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for initial and ongoing provider education are found in Policy NM 159.102, Provider Orientation and Ongoing Training. Network Management staff conduct initial provider orientation within 30 days of the active status date. Ongoing provider education includes any updates issued by SCDHHS and changes in Federal and State mandates, and is conducted because of internal requests, when surveys indicate the need for reeducation, and upon provider request. This education is provided through letters and other mailings, Provider Manual updates, newsletters, in-person training sessions, etc. Select Health conducts regional training sessions throughout the state each year.

Select Health's website includes a "Provider Training and Education" page that includes links for ongoing educational opportunities, Cultural Competency, HEDIS, and behavioral health topics. It was noted that the hyperlinks for two of the Cultural Competency resources, DiversityRx and Polyglot Systems, were nonfunctional. This was mentioned during the previous EQR, and no action was taken to correct these hyperlinks.

Providers are educated about clinical practice guidelines and preventive health guidelines. The guidelines are posted to the website and available through the provider

portal. Hard copies are provided upon request. Providers are assessed on compliance with the guidelines through the medical record review process.

Providers are educated about medical record documentation standards through the Provider Manual. Select Health conducts an annual medical record review audit as described in Policy QI 154.009, Medical Record Review. A passing score is established as 90%, and providers that do not achieve a passing score are notified of identified deficiencies. A follow-up review is conducted, and providers who continue to fall below the minimum score are subjected to corrective action and a final review. An annual summary of the Medical Record Review is provided to the Quality of Clinical Care Committee for review and recommendations. The most recent medical record review was completed in July 2023, with an overall compliance rate of 97.78%.

Network Adequacy Validation

42 CFR § 438.68 (a), 42 CFR § 438.14(b)(1) 42 CFR § 457.1218. 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Constellation Quality Health conducted a validation review of Select Health's provider network following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the MCO is meeting network standards defined by the State. To validate Select Health's network, Constellation Quality Health requested and reviewed:

- Member demographics, including total enrollment and distribution by age ranges, sex, and county of residence
- Geographic access assessments, network development plans, enrollee demographic studies, population needs assessments, provider-to-enrollee ratios, in-network and out-of-network utilization data, provider panel size limitations
- A complete list of network providers
- The total numbers of unique primary care and specialty providers in the network
- A completed Provider Network File Questionnaire
- Provider Appointment Standards and health plan policies
- Provider Manual and Member Handbook
- Sample of a provider contract

A desk review of these documents and a Telephone Access Study was conducted to assess network adequacy.

Overall, Select Health met the requirements of the Network Adequacy Validation. The results of the Telephone Access Study conducted by Constellation Quality Health identified a weakness regarding the provider contact information and the availability of a routine appointment. Details of the Network Adequacy Validation can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

The following is an overview of the results for each activity.

Provider Network File Questionnaire

Constellation reviewed the Provider Network File Questionnaire (PNFQ) and noted that Select Health uses Facets as the provider data management system. Verification of provider data is conducted through a monthly validation by Account Executives. The member facing directory is generated by the vendor HealthSparq and is updated every weekday. Additional activities include validating accuracy of provider information through credentialing and recredentialing processes and annually auditing the online Provider Directory.

Overall, the methods used to assess network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. The ISCA evaluation demonstrated Select Health and its information systems can meet the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.

Availability of Services

Geographic access standards for Primary Care Providers (PCPs), specialists, and hospitals are defined in policies, and the standards are compliant with contractual requirements. To evaluate the network against those standards, Select Health runs quarterly geographic access reports. The geographic access reports dated January 12, 2023, reflect use of appropriate parameters for assessing geographic access to PCPs, using a standard of two providers within 30 miles/45 minutes, and to specialty providers, using a standard of two providers within 50 miles/75 minutes. However, pages 18 and 19 of the Annual Network Development Plan incorrectly state the geographic access distribution standard goals for PCPs is "1 Providers Within 30 miles ≥ 95%" and for specialists is "1 Specialist within 50 Miles ≥ 95%" for all specialty categories.

In addition to the quarterly geographic access reports, Select Health conducts annual assessments of network access and availability, as noted in the Network Development Plan. The annual assessment includes PCPs, high-volume behavioral health providers, high-volume and high-impact specialty practitioners, hospitals, pharmacies, and laboratories. The annual assessments also consider data regarding member experience with accessing the network (from member satisfaction survey results, out-of-network requests, and grievances) and appeal data related to network adequacy.

Table 9: Previous Network Geographic Adequacy QIP lists the deficiency related to network adequacy that was identified during the 2022 EQR, Select Health's response to the QIP, and the current status of the finding.

Table 9: Previous Network Geographic Adequacy QIP

Standard	2022 EQR Findings	2023 EQR Findings
II B. Adequacy of the Provider Network		
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	Policy NM 159.206, Availability of Practitioners, and Policy NM 159.304, Behavioral Health Provider Availability, define geographic access standards for specialists as one provider within 50 miles for at least 95% of the eligible population. Select Health's geographic access report dated October 14, 2022, reflects use of parameters defined in the policies above for assessing geographic access to specialists. All required Status 1 providers are included in the geographic access assessment. The *SCDHHS Contract, Section 6.2.3.1.4* requires MCOs to "Provide a choice of at least 2 required contracted specialists and/or subspecialists who are accepting new patients within the geographic area." Select Health's process for ensuring compliance with this requirement is not addressed in Policy NM 159.206, Availability of Practitioners, and Policy NM 159.304, Behavioral Health Provider Availability. The submitted geographic access report dated October 14, 2022, also did not provide an indication that Select	As stated in policy and evidenced in the geographic access report reviewed, Select Health is ensuring members have access to at least 2 specialty providers within the required geographic access standard. The previously identified issue was corrected.

Standard	2022 EQR Findings	2023 EQR Findings
	Health ensures members have a choice of at least two required specialists/subspecialists within their geographic area. *Quality Improvement Plan: Develop and implement a process to ensure the network provides a choice of at least two required specialists/ subspecialists who are accepting new patients within the member's geographic area, as required by the SCDHHS Contract, Section 6.2.3.1.4.*	
Select Health's Response – Select Health of SC (SHSC) will ensure that it provides a choice of at least 2 required contracted specialists and/or subspecialists who are accepting new patients within the geographic area through quarterly monitoring network adequacy within Quest Analytics software. SHSC's have revised policy NM 159.206, Availability of Practitioners and Policy NM 159.304 Behavioral Health Provider Availability. In addition, SHSC will ensure this is included in the geographic access report. See attached draft of the revised policy NM 159.206 and NM 159.304 to be presented to the P&P meeting on January 19th, 2023.		

Processes are in place to address any identified geographic access issues. When network gaps are noted, a provider outreach strategy is employed. This includes researching prospective providers and confirming they are enrolled with SCDHHS, validating that any prospective providers will provide services needed by members in the service area, and extending a participation agreement to the provider.

Select Health also conducts activities to ensure the provider network can meet members' cultural, language, and other special needs. The health plan collects and analyzes practitioner information, such as race, ethnicity, and languages spoken, and addresses any network gaps identified in these areas. Focus groups/interviews are conducted with members in cultural or linguistic minorities to determine how to meet their needs. Staff and providers are given training and tools to support cultural competence. Also, Select Health conducts analysis for and implements interventions to address significant health care disparities.

Appointment access standards and processes for assessing provider compliance with those standards by conducting call studies are found in Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey. Noncompliance results in implementation of a corrective action plan with the physician. Select Health also conducts ongoing monitoring of grievances, appeals, and

CAHPS survey results related to appointment access to identify any issues and takes action to address them.

Table 10: Previous Appointment Access QIP

Standard	2022 EQR Findings	2023 EQR Findings
II B. Adequacy of the Provider Network		
3. Practitioner Accessibility 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.	Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, defines appointment access requirements but does not include the contractual requirements for wait times for scheduled routine appointments with PCPs or appointment scheduling for walk-in patients with non-urgent needs. Refer to the *SCDHHS Contract, Section 6.2.2.3.* Attachments A and B of Policy NM 159.203 describe processes for assessing after-hours availability and provider compliance with appointment access standards. *Quality Improvement Plan: Revise Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, to include the contractual requirements for wait times for scheduled routine appointments and for walk-in patients with non-urgent needs. Refer to the SCDHHS Contract, Section 6.2.2.3.*	It was noted that Select Health appropriately addressed the QIP from the previous EQR by adding the standards for non-urgent, walk-in care and wait times for a scheduled appointment to the policy.
Select Health - SHSC have revised the policy NM 159.203 Accessibility of Services / PCP After Hours Survey and High Volume Impact Survey to include the contractual requirements for PCP wait times for scheduled routine appointments and for walk-in patients with non-urgent needs. See the attached revised policy NM 159.203 to be presented to the P&P meeting scheduled for January 19, 2023.		

Pages 11 and 12 of the 2022 Network Development Plan display results for the 2022 appointment access study for PCP regular/routine and urgent care appointments. However, the document states the standard for routine new patient appointments is 10 business days, which is inconsistent with the timeframe specified in Policy NM 159.203 and the Provider Manual. It also lists a standard for routine, existing patient appointments of 10 business days, which is not stated in Policy NM 159.203 or the Provider Manual.

Select Health documents required elements of Provider Directories in Policy NM 159.308, Assessment of Physician Directory Accuracy. The policy states provider updates are made in the provider data management system within five business days and changes to the database refresh into the online directory nightly. All required elements are noted in the online and printed Provider Directories.

Provider Access and Availability Study

As part of the annual EQR process for Select Health, a provider access study was conducted by Constellation focusing on PCPs. From a list of current providers given to Constellation by Select Health, a population of 2,802 unique PCPs was identified. A sample of 210 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access members have to the providers. In reference to the results of the Telephone Provider Access Study conducted by Constellation, calls were successfully answered 55% of the time (107 out of 193) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 60%, this year's study rate of 55% was a non-significant decrease in successful calls (p = .317). See *Table 11: Telephonic Access Study Answer Rate Comparison*.

Table 11: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	Fisher's exact p-value
2022 Review	202	60% (120 of 199)	.997
2023 Review	210	55% (107 of 193)	

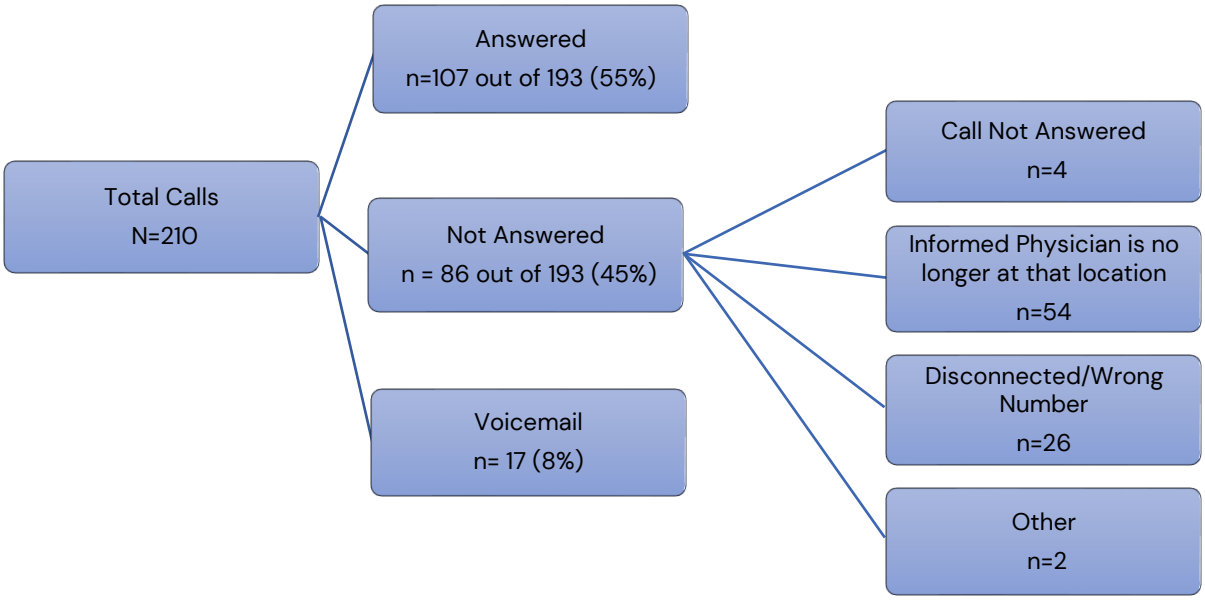
For calls not successfully answered (n= 86 calls), 54 (63%) were due to the physician no longer being active at that location; 28 (33%) were due to a wrong number, hold time longer than five minutes, or busy signal; and four (5%) were due to the call not being answered.

Of the 107 providers successfully contacted, 103 (96%) reported that they accept Select Health, and four (4%) reported they did not accept Select Health. Of the 103 who do accept Select Health, 74 (72%) are accepting new patients and 29 (28%) are not.

Routine appointments were available within the contract requirements (30 days) for 26 (35%) of the 74 providers that are accepting new patients. A total of 48 providers (65%) reported appointment availability outside of the required timeframe.

Results of the call study are displayed in *Figure 3: Telephonic Provider Access Study Results*.

Figure 3: Telephonic Provider Access Study Results



As noted in *Figure 4: Provider Services Findings*, 98% of the standards in the Provider Services section were scored as "Met."

Figure 4: Provider Services Findings

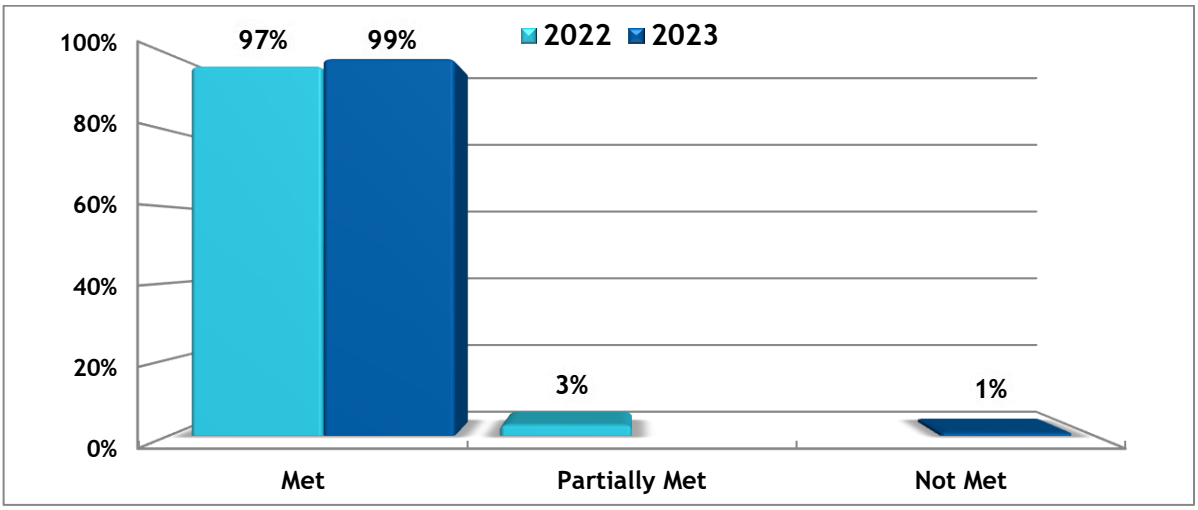


Table 12: Provider Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Adequacy of the Provider Network	The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: 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	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	Partially Met	Met
	The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results	Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Table 13: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Credentialing and recredentialing processes are thoroughly documented in policies and the Credentialing Program Description.	✓		
The Credentialing Committee includes network providers with a variety of specialties, along with health plan management and staff.	✓		
Select Health's network is compliant with State-specified geographic access standards and includes all required Status 1 provider types.			✓
Various activities are conducted to ensure the provider network can serve members with special needs and those with cultural diversity.			✓
Provider education in accomplished through a variety of forums, and Select Health holds multiple regional provider education sessions yearly.	✓		

Table 14: Provider Services
Weaknesses, Recommendations, or Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
One initial credentialing file and one recredentialing file for nurse practitioners did not include admitting arrangements. Select Health responded that the admitting arrangements were addressed in the Nurse Practitioner Collaborative Agreement within the files. However, review of the collaborative agreements showed that they did not specifically address admitting arrangements.	Recommendation: Ensure all credentialing and recredentialing files include admitting privileges or an established arrangement with another practitioner to admit on the applicant's behalf.			✓
One initial credentialing file reflected that Select Health did not follow the process specified in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing for verification of the provider's CLIA certificate.	Recommendation: Ensure verification of all documents within the required timeframes and following processes outlined in health plan policy.	✓		
Select Health's geographic access report dated January 12, 2023, reflects use of appropriate parameters for assessing geographic access to PCPs. It was noted that Select Health measures PCP access using a standard of 2 providers within 30 miles/45 minutes. However, page 18 of 243 of the Annual Network Development Plan states the geographic access distribution standard goal for PCPs is "1 Providers Within 30 miles ≥ 95%."	Recommendation: Revise the Annual Network Development Plan to list the correct geographic access parameters for PCPs.			✓
Select Health's geographic access report dated January 12, 2023, reflects use of appropriate parameters for assessing geographic access to specialty providers. However, page 19 of 243 of the Annual Network Development Plan states the geographic access distribution standard goal is "1 specialist within 50 miles ≥ 95%" for all specialty categories.	Recommendation: Revise the Annual Network Development Plan lists correct parameters for specialists.			✓
The 2022 Network Development Plan displays results of the 2022 appointment access study for primary care provider regular/routine and urgent care appointments; however, it lists the standard for routine new patient appointments as 10 business days. This is inconsistent with the timeframe specified in Policy NM 159.203 and the Provider Manual. It also lists the standard for routine, existing patient appointments of	Recommendation: Correct the standard for routine new patient and routine existing patient appointments in the Select Health of South Carolina Accessibility of Services for Reporting Timeframe: 2022.			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
10 business days, which is not stated in Policy NM 159.203 or the Provider Manual.				
For the Telephone Provider Access Study, conducted by Constellation, calls were successfully answered 55% of the time (107 out of 193) when omitting calls answered by personal or general voicemail messaging services. The success rate declined from the previous year's rate of 60%. Routine appointments were available within the contract requirements (30 days) for 26 (35%) of the 74 providers that are accepting new patients. A total of 48 providers (65%) reported appointment availability outside of the required timeframe.	Quality Improvement Plan: Continue current processes that are conducted to update and validate provider contact information. Look for additional ways to improve provider contact information, such as increasing the frequency of monitoring and verifying provider contact information. Also, reeducate all providers about required appointment access standards.			✓
Select Health's website includes a "Provider Training and Education" page that includes links for ongoing educational opportunities, Cultural Competency, HEDIS, and behavioral health topics. It was noted that the hyperlinks for two of the listed resources, DiversityRx and Polyglot Systems, were nonfunctional, returning error messages when attempting to access the information. This was mentioned during the previous EQR, and no action was taken to correct these hyperlinks.	Recommendation: Correct the non-functional links to DiversityRx and Polyglot Systems on the Select Health website.	✓		

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The written Credentialing Program 2023 (Credentialing Program Description) provides an overview of the scope, goals, structure, and criteria for Select Health's credentialing processes and program. Detailed information about requirements for initial credentialing and recredentialing are found in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, and Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The Board of Directors provides oversight of the Quality Program, and delegates oversight of the Credentialing Program to the Quality Assessment Performance Improvement (QAPI) Committee. The Credentialing Committee is a subcommittee of the QAPI Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Responsibilities of the Credentialing Committee include: • Setting quality standards for the Credentialing Program. • Conducting quality review of information contained in the application and determining if practitioners/organizational providers meet standards. • Approving actions for practitioners and organizational providers that do not meet standards. • Reporting credentialing determinations to the QAPI Committee. The Market Chief Medical Officer is responsible for overseeing the Credentialing Committee and providing clinical oversight of credentialing activities. The Chief Medical Officer can make determinations for clean credentialing and recredentialing files. The Credentialing Committee Charter indicates membership of the Credentialing Committee includes 3–10 voting members, and may include Primary Care Providers (PCPs), specialists, nurse practitioners, dentists,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						behavioral health providers, and allied health providers. The most recent Credentialing Committee minutes submitted for review (dated June 21, 2023) shows the voting membership includes practitioners with a variety of specialties including family practice/family medicine, psychology, pediatrics, internal medicine, obstetrics and gynecology, and surgery. Review of Credentialing Committee minutes for August 24, 2022, through June 21, 2023, reflected the presence of a quorum for each meeting. No issues were noted with member attendance.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
OIG List of Excluded Individuals and Entities (LEIE);						
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					One initial credentialing file for a nurse practitioner did not include admitting arrangements. Select Health responded that the admitting arrangements are addressed in the Nurse Practitioner Collaborative Agreement within the file. However, review of the collaborative agreement showed that it did not specifically address arrangements or a plan for admitting patients. *Recommendation: Ensure all credentialing files include admitting privileges or an established arrangement with another practitioner to admit on the applicant's behalf.*
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.16 Additional Requirements for Nurse Practitioners.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					In one file, the Clinical Laboratory Improvement Amendments (CLIA) verification was dated March 1, 2022, and the approval of network participation was issued on December 9, 2022. This was discussed with Select Health, and after the onsite, Select Health responded that: "CLIA information is maintained at the Group location level in our Credentialing system. At credentialing/recredentialing, if the CLIA certificate is not included with the application's supporting documents, the Credentialing Coordinator reviews the most recent verification information at the Group level to ensure the CLIA is current." However, Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, states, "Any practitioner who has lab services in an office where they are treating members must submit a current CLIA certificate. If a copy of the certificate is not received, the Provider Enrollment Services Department will

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						verify an active CLIA certificate on the website noted in Attachment A." Review of Attachment A states the CLIA will be verified on CMS' website. Therefore, it appears Select Health is not following the process described in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing. *Recommendation: Ensure verification of all documents within the required timeframes and following processes outlined in health plan policy.*
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					One recredentialing file for a nurse practitioner did not include admitting arrangements. Select Health responded that the admitting arrangements are addressed in the Nurse Practitioner Collaborative Agreement within the file. However, review of the collaborative agreement showed that it did not specifically address arrangements or a plan for admitting patients. *Recommendation: Ensure all recredentialing files include admitting privileges or an established arrangement with another practitioner to admit on the applicant's behalf.*
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Additional Requirements for Nurse Practitioners.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Select Health investigates potential concerns and refers providers to the Credentialing Committee, when applicable, for further review and possible action, up to and including panel restriction, suspension, or termination from the network. Providers may be reported to the National Practitioner Data Bank, regulatory agencies, and other appropriate authorities. Detailed information about Select Health's process for sanctioning practitioners/providers and notifying them of any actions taken for quality of care or quality of service issues is found in Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					No issues were noted in the initial credentialing and recredentialing files for organizational providers.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Monthly checks are conducted of licensing boards, the NPDB, OIG LEIE, SAM, SSDMF, and SCDHHS Program Integrity lists. Select Health has contracted with a third-party service, Provider Trust, to conduct the monthly OIG

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						LEIE and SAM monitoring. Policy CR.104.SC describes processes followed when a provider is identified through these monitoring activities. Potential matches are reported to the Compliance, Network Management, and Network Operations departments. Providers may be referred to the Credentialing Committee for discussion and determination of appropriate intervention or may be immediately terminated from the network, depending on severity. Processes are in place for notifying SCDHHS' Division of Program Integrity of actions taken against any provider.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy NM 159.206, Availability of Practitioners define geographic access standards for PCPs as one provider within 30 miles for at least 95% of the population. PCPs include Family Practice/General Practice, Pediatrics, and Internal Medicine providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Select Health's geographic access report dated January 12, 2023, reflects use of appropriate parameters for assessing geographic access to PCPs. It was noted that Select Health measures PCP access using a standard of two providers within 30 miles/45 minutes. However, page 18 of the Annual Network Development Plan states the geographic access distribution standard goal for PCPs is "1 Providers Within 30 miles ≥ 95%." *Recommendation: Revise the Annual Network Development Plan to list the correct geographic access parameters for PCPs.*
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Select Health conducts annual assessments of network access and availability, as noted in the Network Development Plan. The annual assessment includes PCPs, high-volume behavioral health, and high-volume and high-impact specialty practitioners, as well as hospitals, pharmacies, and laboratories. The annual assessments also consider member experience with accessing the network (member satisfaction survey results, out-of-network requests, and grievances) and appeal data related to network adequacy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy NM 159.206, Availability of Practitioners, and Policy NM 159.304, Behavioral Health Provider Availability, define geographic access standards for specialists as two providers within 50 miles for > 95% of the eligible population. Select Health's geographic access report dated January 12, 2023, reflects use of appropriate parameters for assessing geographic access to specialty providers. However, page 19 of the Annual Network Development Plan states the geographic access distribution standard goal is "1 specialist within 50 miles ≥ 95%" for all specialty categories. *Recommendation: Revise the Annual Network Development Plan to list correct parameters for specialists.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Select Health runs quarterly geographic access reports. In addition to reviewing and analyzing the geographic access reports, Select Health monitors member to provider ratios, member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						complaints and grievances, out of network requests, etc.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Select Health conducts a variety of activities to ensure its provider network can meet members' cultural, language, and other special needs. Activities include but are not limited to: • Collecting and analyzing practitioner race, ethnicity, and language data and implementing interventions to address any identified network gaps for these areas. • Conducting focus groups/interviews with cultural or linguistic minority members to determine how to meet their needs. • Providing information, training, and tools to staff and practitioners to support culturally competent communication and materials. • Analyzing significant health care disparities and identifying interventions to reduce disparities. • Including information about provider languages and language services offered in online and printed Provider Directories.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is	X					The Network Development Plan states, "If network adequacy opportunities are identified through this assessment, SHSC will employ its provider outreach strategy which includes, but

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
identified as not meeting membership demand.						is not limited to: thorough research of prospective providers, confirmation that the prospective providers are enrolled with SCDHHS, validation that the prospective providers will provide services needed by SHSC's members in the provider's service area, and approval by the Director of Provider Network Management (PNM). If network participation approval is received by the Director of PNM, the PNM Account Executive (AE) will discuss with the prospective provider and extend a participation agreement."
1.6 The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. Select uses Facets as the data management system. Verification is conducted through a monthly Account Executive validation of the provider data. The member facing directory is updated daily on weekdays and generated from the vendor, HealthSparq.
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
2.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to	X					Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, defines appointment access standards and outlines processes for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
practitioners and that are consistent with contract requirements.						assessing provider compliance with those standards. Select Health conducts call studies to assess appointment access compliance and compliance with requirements for 24 hour-a-day accessibility. Noncompliance results in implementation of a corrective action plan with the physician. Select Health also conducts ongoing monitoring of grievances, appeals, and CAHPS survey results related to appointment access. It was noted that Select Health appropriately addressed the quality improvement plan from the previous EQR by adding the standards for non-urgent, walk-in care and wait times for a scheduled appointment.
2.2 The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					Pages 11 and 12 of the 2022 Network Development Plan display results for the 2022 appointment access study for primary care provider regular/routine and urgent care appointments. The document lists the standard for routine new patient appointments as 10 business days; however, this is inconsistent with the timeframe specified in Policy NM 159.203. It also lists the standard for routine, existing patient appointments of 10

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						business days, which is not stated in Policy NM 159.203. Also, these 10 business-day timeframes are inconsistent with the appointment access timeframes specified in the Provider Manual, page 47. A copy of the full 2022 Select Health of South Carolina Accessibility of Services report was provided after the onsite. Page four of the report lists the results of the 2022 access study and indicates the standard for PCP routine new patient and routine existing patient appointments is four to six weeks, as stated in policy and in the Provider Manual. *Recommendation: Correct the standard for routine new patients and routine existing patient appointments in the Select Health of South Carolina Accessibility of Services for Reporting Timeframe: 2022.*
2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.	X					Policy NM 159.308, Assessment of Physician Directory Accuracy, defines elements that must be included in Provider Directories. As noted in the policy, routine updates are made to the online directory daily when changes in provider information are received from

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Account Executives or directly from providers. These changes are made to the Facets database within five business days unless an expedited change is requested. Changes to the Facets database refresh into the online directory nightly. All required elements are noted in the online and printed Provider Directories.
2.4 The MCO conducts appropriate activities to validate Provider Directory information.	X					Policy NM 159.308, Assessment of Physician Directory Accuracy, describes processes for the annual evaluation of provider data accuracy and information in the Provider Directory. In addition, it addresses additional, more frequent, activities that are conducted to evaluate the accuracy of physician data elements that are reflected in the Provider Directory. Activities include: • Validating accuracy of provider information through credentialing and recredentialing processes and during provider visits by Account Executives. • Annual auditing of the online directory • Ensuring data in the Credentialing database matches the Facets database, which is the source of physician directory.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Monthly reports of physicians who are missing any required data elements in Facets.
2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.			X			As part of the annual EQR process for Select Health Plan, a provider access study was performed focusing on PCPs. A list of current providers was given to Constellation by Select Health, from which a population of 2,802 unique PCPs were found. A sample of 210 providers were 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. In reference to the results of the Telephone Provider Access Study, conducted by Constellation, calls were successfully answered 55% of the time (107 out of 193) when omitting calls answered by personal or general voicemail messaging services. The success rate declined from last year's rate of 60%. When compared to last year's results of 60%, this year's study rate of 55% was a non-significant decrease in successful calls (p = .317). For those not answered successfully (n=

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						86 calls), 54 (63%) were due to the physician no longer being active at that location; 28 (33% were due to a wrong number, hold time longer than five minutes, or busy signal, and four were due to call not being answered (5%). Of 107 providers successfully contacted, 103 (96%) accepted Select health and four (4%) did not accept Select Health. Of the 103 who are accepting Select Health, 74 (72%) are accepting new patients; 29 (28%) are not accepting new patients. A routine appointment was available within the contract requirements (30 days) for 26 (35%) of the 74 that are accepting new patients and outside the required timeframe for 48 (65%). *Quality Improvement Plan: Continue current processes that are conducted to update and validate provider contact information. Look for additional ways to improve provider contact information, such as increasing the frequency of monitoring and verifying provider contact information. Also, reeducate all providers about required appointment access standards.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The state has time/distance requirements documented for primary care, OB/GYN, and specialty providers. The methods utilized for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy NM 159.102, Provider Orientation and Ongoing Training, describes processes for initial provider orientation, conducted by Network Management staff within 30 days of the active status date. A checklist of topics is used, and the topics are listed in the policy.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Select Health conducts ongoing provider training as needed for updates issued by SCDHHS, changes in Federal and State mandates, internal requests, survey results, and upon request from providers. Forums for providing additional education include letters and other mailings, Provider Manual updates, newsletters, in-person training sessions, etc. These processes are detailed in Policy NM 159.102, Provider Orientation and Ongoing Training. Select Health's website includes a "Provider Training and Education" page that includes links for ongoing educational opportunities, Cultural Competency, HEDIS, and behavioral health topics. It was noted that the hyperlinks for two of the listed resources, DiversityRx and Polyglot Systems, were nonfunctional, returning error messages when attempting to access the information. This was initially noted during the previous EQR and discussed with the health plan. There was no action taken to address the recommendation to correct these hyperlinks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						As noted on the website, Select Health conducts regional training sessions throughout the state. *Recommendation: Correct the non-functional links to DiversityRx and Polyglot Systems on the Select Health website.*
II D. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health and clinical practice guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The Quality Management Program Description 2023 provides an overview of the process for developing, approving, distributing, monitoring, and revising clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) for practitioners. The program description describes the purpose of the guidelines as: "to facilitate the delivery of consistent, evidence-based, cost-effective quality care and the reduction in variability in physician practice and medical care delivery." It further states CPGs and PHGs are developed using criteria from nationally recognized professional organizations, and that health plan practitioners provide input for the guidelines.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The guidelines are reviewed, at minimum, every two years (more often if there are changes to the guidelines). Guidelines are posted to the website and available through the provider portal. Hard copies are provided upon request. These processes are reflected in Policy 391.1003, Preventive and Clinical Practice Guidelines.
2. The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members.	X					Guidelines are posted to the website and available through the provider portal. Hard copies are provided upon request. The Provider Manual informs providers about the guidelines, the process for review and adoption, and that the guidelines are available on Select Health's website. The Provider Resources section of Select Health's website provides a link to the list of approved guidelines.
3. The guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Policy 154.011, QI Monitoring Continuity and Coordination of Care, states Select Health's Quality Management Department monitors and trends continuity and coordination of care at least annually. Feedback is provided to appropriate quality committees and individual practitioners, and a continuity and coordination of care summary report is presented to the Quality Assessment and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Performance Improvement Committee annually. The policy states continuity and coordination of care is monitored between PCPs and specialists, hospitals/emergency rooms, acute care facilities, home health agencies, skilled nursing facilities, behavioral health providers and organizations, pharmacy providers, and other ancillary provider types. Mechanisms for assessing continuity and coordination of care include medical record reviews, monitoring grievance and appeal data, survey results, monitoring quality of care concerns, etc.
II F. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Select Health's annual Medical Record Review process is found in Policy QI 154.009, Medical Record Review. A passing score is established as 90%, and providers that do not achieve a passing score are notified of identified deficiencies. A follow-up review is conducted, and providers who continue to fall below the minimum score are subjected to corrective action and a final review. An annual summary of the Medical Record Review is provided to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Quality of Clinical Care Committee for review and recommendations.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					The Medical Record Audit Tool is included in Policy 154.009. Both the policy and tool contain all required medical record documentation elements. The Provider Manual is a resource for providers to understand the required elements for medical record documentation.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The Annual Assessment of State Audits for Medical Record Documentation indicates the Medical Record Review was completed in July 2023. The overall compliance rate was 97.78% for a random sample of 20 provider practices.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

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 includes member rights and responsibilities, member education, processes for member enrollment and disenrollment, the member satisfaction survey, and grievance processes.

Member rights and responsibilities are documented in health plan policy as well as in the Member Handbook and Provider Manual. Members are informed of their rights in various ways. At enrollment, members are informed of their rights verbally via Member Service Representative outreach at enrollment for new member orientation. The new member packet provided at enrollment instructs members about how to access or receive a paper copy of the rights and responsibilities. Member rights and responsibilities are also included in member newsletters and on the health plan's website.

Select Health has appropriate processes established to provide the new member packet to members within 14 calendar days of receipt of enrollment information from SCDHHS. The new member packet includes pertinent information for a newly enrolled member to understand health plan processes and requirements, provides instruction for how to request additional information, and provides contact information for questions. The member ID card is issued by the 15th day of the month of the member's enrollment.

The Member Handbook, available on the website or upon request, is comprehensive and includes information about covered and excluded benefits, benefit limitations, processes for obtaining prior authorization when required, etc. It was noted that the Member Handbook did not address non-hospital based rehabilitative therapies for children as a covered benefit as indicated in the *SCDHHS Contract, Section 4.2.22*. Members can access detailed information about copayment requirements on the Copayment Reference Guide on Select Health's website or by contacting Member Services. The Member Services Call Center is available via a toll-free telephone number from 8 am to 6 pm Monday through Friday and from 8:30 am to 5 pm on weekends. The 24/7 Nurse Call Line is available via a toll-free telephone number around the clock for medical advice.

The Member Handbook stresses the importance of routine PCP care and preventive care and provides information about specific programs that are available for pregnancy, diabetes, cardiovascular disease, and sickle cell disease. Policy QI 154.006,

EPSDT/ Prevention and Screening Outreach, addresses coverage of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and required components. The policy indicates Select Health provides reminders to members of recommended services. Information about EPSDT services is included in the Member Handbook, and members may log into the secure Member Portal to view the services that are due. In addition, the MCO runs reports of members who are due for services. Using the results of these reports, outreach is conducted and/or reminders are sent.

The health plan's processes for notifying members of changes in services, benefits, and the provider network are appropriate and compliant with contractual requirements. Members are notified of changes in the benefits or services in writing at least 30 days before the effective date of the change. For provider terminations, members receive 30 days' written notice before the effective date of the termination, or within 15 days of receipt of the notice of termination, whichever is later. Assistance is provided to aid members in selecting an alternate provider.

Select Health has established processes to ensure member materials are produced in a manner to ensure member understanding. The reading level of written member materials is no higher than 6.9 per the Flesch-Kincaid scale. All member materials are produced in both English and Spanish formats and can be created in any additional threshold languages. Vital documents can be translated into other languages upon request. No-cost interpreter services are provided, and member materials can be provided in alternate formats such as large font, Braille, audio formats, etc.

Policy MEM 129.102, Disenrollment - Voluntary and Involuntary, defines processes and requirements for member disenrollment. Members are educated about requirements for voluntary disenrollment via the Member Handbook. The information describes when and how members can request disenrollment from the health plan and provides appropriate reasons for requesting disenrollment at other times. The Member Handbook also addresses circumstances under which a member may be involuntarily disenrolled. Members are instructed to contact Member Services or Healthy Connections Choices for more information.

Member Satisfaction Survey

Select Health contracts with Press Ganey, a certified vendor who acquired SPH Analytics, to conduct the adult and child satisfaction surveys. As noted in the Quality of Service Committee (QSC) minutes for June 2023, Press Ganey summarized and detailed all results from adult and child surveys.

The adult response rate was 13.2% (223 out of 1690), which is a slight decline from last year's response rate of 13.4%. The findings showed improvement in Rating of Health Plan, Getting Care Quickly, and Rating of Personal Doctor. The largest decline was in the Rating of Specialist.

The child response rate was 16.7% (400 out of 2,392 surveys), which is an increase over last year's rate of 13.7%. Improvement occurred for Rating of Personal Doctor. The largest decline was in the Rating of Health Care.

The Child with CCC response rate was 16% (264 out of 1645), which is an improvement over the previous year's rate of 12.8%. For this population, Getting Care Quickly, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist improved from the previous year. The largest decline for the CCC population was Customer Service.

Ethnicity and race differences were analyzed. Per the QSC minutes for June 2023, Select Health is working to reconvene the local CAHPs group. Results were presented to the QSC in June 2023. The Quality and Appeals and Grievances departments also reviewed the results.

Grievances

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

Select Health's procedures for processing grievances are detailed in Policy MMS.100, Member Grievances and Appeals Process. Information about the handling of grievances, timelines, receipt, extensions if needed, and resolution can be found in Select Health's Member Handbook, Provider Manual, and on the website. Policy MMS.100, Member Grievances and Appeals Process, defines a grievance as not being satisfied with any matter other than an adverse benefit determination. Policy 591.001, Records Retention Policy and Schedule, indicates that Select Health retains records for a fixed period of 10 years. A random sample of grievances reviewed for the 2023 EQR found that grievances were processed timely and within contractual guidelines. Two grievance files did not include a resolution letter within the timeline outlined in policy MMS.100, Member Grievances and Appeals Process. This was discussed during the onsite.

As noted in *Figure 5: Member Services Findings*, 100% of the standards in the Member Services section were scored as "Met."

Figure 5: Member Services Findings

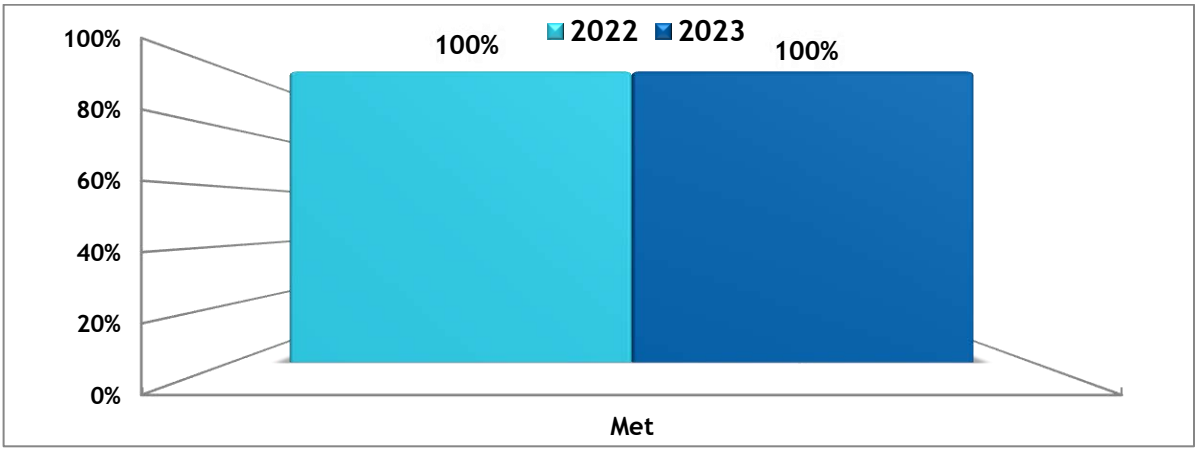


Table 15: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members are informed of their rights and responsibilities in various ways, including outreach calls, the Member Handbook, newsletters, etc.	✓		
Members are educated about benefits, services, health plan processes, etc. through the Member Handbook, the new member packet, etc. Member Services staff are available to answer member questions.	✓		
Appropriate processes are in place to inform members of changes in services, benefits, and the provider network.			✓
Member materials are written to ensure member understanding and are available in alternate languages and formats. Translation and interpreter services are provided at no cost.			✓
Processes for voluntary and involuntary disenrollment are compliant with contractual requirements.	✓		
A random sample of grievances reviewed for the 2023 EQR found that grievances were processed timely and within contractual guidelines.		✓	

Table 16: Member Services Weaknesses, Recommendations, or Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Most core member benefits are covered in the Member Handbook; however, it does not address non-hospital based rehabilitative therapies for children, as required by the *SCDHHS Contract, Section 4.2.22*.	Recommendation: Ensure all core benefits are included in the benefits information in the Member Handbook.			✓

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy MEM 129.100, Member Rights and Responsibilities, indicates members are informed of their rights in various ways, including in writing via the new member packet at enrollment, which instructs members about how to access or receive a paper copy of the information, annually via member newsletters, and on the health plan's website. Additionally, members are informed of their rights verbally via Member Service Representative outreach at enrollment for new member orientation.
2. Member rights include, but are not limited to, the right:	X					Member rights are consistently documented across Policy MEM 129.100, Member Rights and Responsibilities, the Member Handbook, the Provider Manual, and on the health plan's website.
2.1 To be treated with respect and with due consideration for dignity and privacy;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy MEM 129.107, New Member Orientation Calls, indicates the new member packet is mailed within 14 calendar days of receipt of enrollment information from SCDHHS.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, the member ID card is issued by the 15th day of the month of the member's enrollment. The 2022 Member Handbook List of Changes document was found on Select Health's website. It lists changes made to the Handbook as well as the effective date and affected sections and page numbers. The Bright Start Initial Delivery Outreach Workflow document confirms that members who are not enrolled in Care Management are reminded that their newborn will be automatically enrolled into Select Health unless the member selects a different health plan.
1.1 Benefits and services included and excluded in coverage;						Most core member benefits are covered in the Member Handbook. However, it does not address non-hospital based rehabilitative therapies for children as required by the *SCDHHS Contract, Section 4.2.22*. *Recommendation: Ensure all core benefits are included in the benefits information in the Member Handbook.*
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						The Member Handbook instructs that members can obtain information about copayment amounts on the Copayment Reference Guide on Select Health's website. Members may also contact Member Services to obtain a printed copy of the information.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The Member Handbook defines emergent versus urgent care, provides examples of conditions or situations where each are appropriate, and states that members can seek advice about the appropriate level of care from their PCP or the 24/7 Nurse Call Line.
1.7 Policies and procedures for accessing specialty care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Members are informed about processes and requirements related to prescription medications, including supply limitations, emergency supply of medications, etc. Brief information is included about durable medical equipment and related copayments.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Information about the role of the PCP, processes for selecting and changing the PCP, and types of providers that can serve as a PCP are included in the Member Handbook.
1.11 Procedures for disenrolling from the MCO;						The "Enrollment/Disenrollment Information" section of the Member Handbook provides information about when and how members can request disenrollment from the health plan and provides appropriate reasons for requesting disenrollment at other times. The Handbook also informs that members may be involuntarily disenrolled for various reasons, which are listed. Members are instructed to contact Member Services or Healthy Connections Choices for more information. Contact information is provided.
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						Descriptions of both the First Choice ID card and Healthy Connections ID card are included in the Member Handbook, along with an explanation that the cards should be carried at all times and shown when receiving services from providers, facilities, pharmacies, etc. Members are instructed about how to get additional copies of their ID card, accessing an electronic copy of the card on the mobile app, and using the app to fax a copy of the ID card to providers.
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Policy MEM 129.100, Member Rights and Responsibilities, states it is a member's right "To receive notice of any significant changes in the Benefits Package at least thirty (30) calendar days before the intended effective date of the change." Policy MEM 129.105, Member Services Department, states Member Services staff

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						notify of significant changes in the benefits or services package members in writing at least 30 days before the effective date of the change. Policy MEM 129.117, Termination of Primary Care Provider, and Policy MEM 129.125, Termination of a Specialist or Hospital, describe processes for notifying members of PCP, specialist, and hospital terminations. As stated in the policies, members are notified in writing at least 30 calendar days before the effective date of the termination, except when the MCO receives less than 30 days' notice from the provider. In that case, members are notified in writing within 15 calendar days of receipt of notification of the termination. The written notice includes will include the name of provider/practice and guidance for selecting another practitioner.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy COM 220.100, Collateral Approval – South Carolina Department of Health and Human Services, states Select Health ensures the reading level of member materials is 6.9 or below using the Flesch-Kincaid scale. Policy COM 220.105, The Production of Vital Documents in Alternative Formats, confirms

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						that all member materials are produced in English and Spanish. However, Select Health monitors members' preferred languages to identify any new threshold languages and will include any identified languages in the member materials. It was noted that vital documents can be translated upon request into other languages.
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					Page two of the Member Handbook states the Member Services Call Center is available via a toll-free telephone number from 8 am to 6 pm Monday through Friday. The call center if available on weekends from 8:30 am to 5 pm for pharmacy-related calls. The 24/7 Nurse Call Line is available via a toll-free telephone number around the clock for medical advice. Policy MEM 129.116, Member Services Coverage, defines requirements for staffing and coverage for the Member Services Call Center. Included in the policy are normal business hours as well as weekend and holiday coverage. Select Health's Interactive Voice Response system instructs members to call 911 or go to an emergency room for life threatening emergencies, provides information for contacting the member's PCP and Nurse Line, and provides an option to leave a message

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						with response to be provided within one business day.
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Policy MEM 129.109, PCP Selection and Changes, describes processes for member-requested and automatic PCP assignment. If a member has already chosen a PCP when the monthly eligibility file is received, they are assigned by Select Health to the chosen PCP. For other members, Select Health encourages early PCP selection and assists members during the telephonic new member orientation. If unable to contact the new member, a PCP is automatically assigned using an algorithm that considers other family member PCP assignments, geographic location, age, and gender.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					As noted in Policy MEM 129.102, Disenrollment - Voluntary and Involuntary, members may ask to be disenrolled once within the first 90 days of initial enrollment or re-enrollment and then once every twelve months. After the initial 90 days, members may request disenrollment at any time with cause. The policy specifies appropriate reasons for requesting disenrollment for cause. Members must contact South Carolina Healthy Connections

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Choices to request disenrollment. SCDHHS makes the final determination for member-initiated disenrollment requests. Select Health can request disenrollment of a member for various reasons, as noted in Policy MEM 129.102, Disenrollment - Voluntary and Involuntary. The plan-initiated disenrollment request must be submitted to SCDHHS in writing and include detailed reasons for the request as well as any supporting documentation. SCDHHS makes the final determination and notifies both the MCO and the member.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					The Member Handbook includes information about the importance of obtaining EPSDT services and well visits, as well as routine women's health services and screenings. The Member Handbook in general stresses the importance of routine PCP care and provides information about specific programs that are available for pregnancy, diabetes, cardiovascular disease, and sickle cell disease.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					Policy QI 154.006, EPSDT/ Prevention and Screening Outreach, addresses coverage of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services and required components. The policy indicates Select Health provides reminders to members of recommended services. Information about EPSDT services is included in the Member Handbook and members may log into the secure Member Portal to view the services that are due. In addition, the MCO runs reports of members who are due for services. Using the results of these reports, outreach is conducted and/or reminders are sent.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Select Health contracts with Press Ganey, a certified vendor who acquired SPH Analytics, to conduct the adult and child surveys.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					As noted in the Quality of Service Committee minutes for June 2023, Press Ganey summarized and detailed all results from adult and child surveys. For the adult survey, the response rate was 13.2% (223 out of 1690), which is a slight decline from last year's response rate of 13.4%. The findings showed improvement in Rating of Health Plan, Getting Care Quickly, and Rating of Personal Doctor. The largest decline was in the Rating of Specialist. The child response rate was 16.7% (400 out of 2,392 surveys), which is an increase over last year's rate of 13.7%. Improvement occurred for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Rating of Personal Doctor. The largest decline was in the Rating of Health Care. The Child with CCC response rate was 16% (264 out of 1645), which is an improvement over the previous year's rate of 12.8%. For the CCC population, Getting Care Quickly, Coordination of Care, Rating of Personal Doctor, and Rating of Specialist improved from the previous year. The largest decline for the CCC population was Customer Service.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Ethnicity and race differences were analyzed. Per the Quality of Service Committee minutes for June 2023, Select Health is working to reconvene the local CAHPs group.
4. The MCO reports the results of the member satisfaction survey to providers.	X					
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					Results were presented to the Quality of Service Committee in June 2023. The Quality and Appeals and Grievances departments also reviewed the results.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with	X					Procedures for processing grievances are described in policy MMS.100, Member Grievances and Appeals Process. Information about the grievance process can also be found

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
contract requirements, including, but not limited to:						in Select Health's Member Handbook, Provider Manual, and on the website.
1.1 The definition of a grievance and who may file a grievance;	X					A grievance is defined in policy MMS.100, Member Grievances and Appeals Process, the Member Handbook, Provider Manual, and website as not being satisfied with any matter other than an adverse benefit determination.
1.2 Procedures for filing and handling a grievance;	X					Policy MMS.100, Member Grievances and Appeals Process, outlines the requirements from the receipt options through the resolution of internal grievances.
1.3 Timeliness guidelines for resolution of a grievance;	X					The Member Handbook, website, and policy MMS.100, Member Grievances and Appeals Process, document the required timeframes for grievance acknowledgements, extensions if needed, and resolutions.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Policy 591.001, Records Retention Policy and Schedule, indicates that Select Health retains records for a fixed period of ten years.
2. The MCO applies grievance policies and procedures as formulated.	X					The 2023 EQR found that grievances were processed in a manner that was timely and reflected compliance with all requirements.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
opportunities, and reported to the Quality Improvement Committee.						
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

D. Quality Improvement

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

Select Health provided the 2023 Quality Management Program Description for this EQR. This document was developed based on the health plan's 2022 performance and outcomes. The changes were outlined, and the goals and objectives were similar to the goals and objectives in 2022. The 2023 Quality Improvement (QI) Program Description was provided to the QAPI Committee and the Board of Directors for review and approval.

Select Health develops a work plan annually to guide and track ongoing activities throughout the year. The 2022 and 2023 QI work plans were submitted for review. Both works plans contained the QI activities and objectives, time frames for expected completion, responsible parties, and any ongoing monitoring notes. The work plans reflect the ongoing quality activities for the QAPI Committee, the Quality Clinical Care Committee, and the Quality of Service Committee. Each committee is responsible for the review and approval of their section of the work plan.

The QAPI Committee oversees Select Health's quality, utilization, and population health management activities. This committee reports to the health plan's Board of Directors. The committee charter outlines the committee's primary responsibilities. The Quality Clinical Care Committee (QCCC) is a subcommittee of the QAPI Committee. The committee charter indicates this committee provides direction and oversight of the clinical quality and appeals, utilization management, behavioral health management, population health management, chronic care management, and the pharmacy programs. The Quality of Service Committee also reports to the QAPI Committee. This committee is responsible for assuring the performance and quality improvement activities related to Select Health's services are reviewed, coordinated, and effective.

The Market President continues to serve as the chairperson for the QAPI Committee. Other members include the Chief Medical Officer, medical directors, and other senior leaders. Network providers specializing in pediatrics, family medicine, and psychiatry are included as voting members. Committee minutes for meetings held in October 2022, December 2022, February 2023, April 2023, and June 2023 were provided. A quorum was met for each meeting. There were two network providers that did not attend any meetings and were removed from the committee. One medical director also did not attend any of the meetings.

All committees met at regular intervals except the QCCC. The QCCC's charter indicates this committee meets at a minimum of three times per year. However, this committee only met once in 2022. Per Select Health, most of this committee's business was switched to the QAPI Committee due to the availability of the providers serving on the QCCC.

The QI Program Description provided an overview of the Primary Care Physician Report cards that provide direct feedback on the practitioner's performance. Each report card contains the practitioner's performance on key quality measures compared to a peer group within Select Heath's network. Additionally, PCPs can pull member-level dashboard reports to identify care gaps along with a list of up-to-date services for reference.

Per Policy QI 154.006, EPSDT/ Prevention and Screening Outreach, Select Health tracks and monitors members who have not received the recommended Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and immunizations. Providers are notified on a monthly basis of members who are due for services. Select Health also provides a dashboard report, which shows members who have completed services and those with care gaps. Provider Account Executives and staff in the QI department offer assist to providers to help improve compliance with EPDST and immunization services. Select Health uses gift cards and other rewards to incentivize members for healthy behaviors.

The evaluation of the effectiveness of the QI program is conducted annually. Select Health submitted the Quality Management Program Evaluation for Calendar Year 2022. This Program Evaluation included the results of all the activities conducted in 2022. The analysis for each activity was included as well as identified barriers and opportunities for improvements.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

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

Select Health uses Inovalon, a certified software organization for calculation of HEDIS rates. Rates were audited by Healthcare Data Company, LLC. All relevant HEDIS performance measures (PMs) for the current measure year (2022), the previous measure year (2021), and the change from 2021 to 2022 are reported in *Table 17: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial improvement (>10%) and the rates shown in red indicate a substantial decline (>10%).

Table 17: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2021	Measure Year 2022	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	74.47%	70.34%	-4.13%
Counseling for Nutrition	70.21%	59.32%	-10.89%
Counseling for Physical Activity	69.41%	57.06%	-12.35%
Childhood Immunization Status (cis)			
DTaP	72.02%	73.48%	1.46%
IPV	86.13%	87.59%	1.46%
MMR	84.91%	87.59%	2.68%
HiB	82.24%	82.24%	0.00%
Hepatitis B	85.89%	87.35%	1.46%
VZV	84.43%	86.13%	1.70%
Pneumococcal Conjugate	72.75%	73.24%	0.49%
Hepatitis A	84.67%	86.62%	1.95%
Rotavirus	70.8%	71.05%	0.25%
Influenza	36.25%	33.09%	-3.16%
Combination #3	65.69%	64.72%	-0.97%
Combination #7	56.45%	55.96%	-0.49%
Combination #10	27.25%	26.52%	-0.73%
Immunizations for Adolescents (ima)			
Meningococcal	77.37%	77.37%	0.00%
Tdap/Td	85.64%	86.62%	0.98%
HPV	40.39%	37.71%	-2.68%
Combination #1	76.64%	76.64%	0.00%
Combination #2	39.17%	36.50%	-2.67%
Lead Screening in Children (lsc)	67.54%	65.85%	-1.69%
Breast Cancer Screening (bcs)	56.02%	56.18%	0.16%
Cervical Cancer Screening (ccs)	60.65%	62.28%	1.63%
Colorectal Cancer Screening (col)	NR	40.56%	NA

MEASURE/DATA ELEMENT	Measure Year 2021	Measure Year 2022	PERCENTAGE POINT DIFFERENCE
Chlamydia Screening in Women (chl)	58.8%	60.29%	1.49%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	76.30%	82.40%	6.10%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	29.64%	29.93%	0.29%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	62.64%	70.53%	7.89%
Bronchodilator	81.51%	79.57%	-1.94%
Asthma Medication Ratio (amr)	74.21%	70.32%	-3.89%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	59.51%	52.01%	-7.50%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.12%	66.67%	-1.45%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - Total	80.52%	81.65%	1.13%
Statin Adherence 80% - Total	59.48%	62.14%	2.66%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	2.03%	2.99%	0.96%
Cardiac Rehabilitation - Engagement1 (Total)	2.37%	4.27%	1.90%
Cardiac Rehabilitation - Engagement2 (Total)	2.03%	4.27%	2.24%
Cardiac Rehabilitation - Achievement (Total)	0.68%	1.71%	1.03%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	48.66%	50.85%	2.19%
HbA1c Control (<8.0%)	42.82%	42.09%	-0.73%
Eye Exam (Retinal) Performed	47.45%	47.45%	0.00%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (Total)	24.39%	24.53%	0.14%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	62.07%	60.41%	-1.66%
Statin Adherence 80%	54.18%	56.29%	2.11%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	48.03%	48.26%	0.23%
Effective Continuation Phase Treatment	31.16%	30.14%	-1.02%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	36.12%	42.49%	6.37%
Continuation and Maintenance (C&M) Phase	51.53%	57.05%	5.52%

MEASURE/DATA ELEMENT	Measure Year 2021	Measure Year 2022	PERCENTAGE POINT DIFFERENCE
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total - 30-Day Follow-Up	67.1%	64.36%	-2.74%
Total - 7-Day Follow-Up	42.75%	38.24%	-4.51%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Total - 30-Day Follow-Up	64.04%	61.33%	-2.71%
Total - 7-Day Follow-Up	47.62%	46.58%	-1.04%
Diagnosed Substance Use Disorders (DSU)			
Diagnosed Substance Use Disorders - Alcohol (Total)	NR	1.19%	NA
Diagnosed Substance Use Disorders - Opioid (Total)	NR	1.24%	NA
Diagnosed Substance Use Disorders - Other (Total)	NR	2.48%	NA
Diagnosed Substance Use Disorders - Any (Total)	NR	3.94%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	39.73%	36.47%	-3.26%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	25%	20.58%	-4.42%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	15.68%	27.83%	12.15%
Total - 7-Day Follow-Up	11.35%	18.50%	7.15%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	77.22%	78.95%	1.73%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	61.17%	62.99%	1.82%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	70.83%	58.33%	-12.50%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	62.53%	60.76%	-1.77%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - Total	56.84%	56.22%	-0.62%
Cholesterol Testing - Total	35.98%	37.05%	1.07%
Blood glucose and Cholesterol Testing - Total	34.37%	34.05%	-0.32%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.67%	0.44%	-0.23%
Appropriate Treatment for Children With URI (uri)			
Total	87.97%	88.33%	0.36%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	47.66%	54.71%	7.05%
Use of Imaging Studies for Low Back Pain (lbp)	72.83%	71.25%	-1.58%
Use of Opioids at High Dosage (hdo)	4.23%	3.95%	-0.28%
Use of Opioids From Multiple Providers (uop)			

MEASURE/DATA ELEMENT	Measure Year 2021	Measure Year 2022	PERCENTAGE POINT DIFFERENCE
Multiple Prescribers	18.42%	19.74%	1.32%
Multiple Pharmacies	2.57%	2.06%	-0.51%
Multiple Prescribers and Multiple Pharmacies	1.65%	1.48%	-0.17%
Risk of Continued Opioid Use (cou)			
Total - >=15 Days covered	1.99%	3.03%	1.04%
Total - >=31 Days covered	0.98%	1.07%	0.09%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
Total	79.1%	76.00%	-3.10%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: Total	40.0%	39.25%	-0.75%
Engagement of AOD Treatment: Total	12.46%	10.63%	-1.83%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	86.9%	89.19%	2.29%
Postpartum Care	77.96%	76.01%	-1.95%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	62.57%	61.54%	-1.03%
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)	51.38%	55.47%	4.09%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	73.28%	71.28%	-2.00%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	49.89%	46.78%	-3.11%

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

A substantial decline of 10% or more was noted for Counseling for Nutrition and Counseling for Physical Activity for Children declined by 10.89% and 12.35%, respectively. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia declined 12.5%. In terms of year over year improvement, Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, 30-day follow-up improved 12.15% from last year.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects." 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)	Sampling methodology (if used)
Study question(s)	Data collection procedures
Study indicator(s)	Improvement strategies
Identified study population	

Two PIPs were submitted for validation. Topics included Diabetes Outcomes Measures and Well Care Visits for the Foster Care Population. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions are included.

Table 18: Diabetes Outcomes Measures PIP

Diabetes Outcomes Measures	
The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8). The Diabetes Outcomes PIP showed a slight decline in the HBA1C measure (42.82% to 42.09%) and the Blood Pressure Control measure (63.02% to 61.31%).	
Previous Validation Score	Current Validation Score
91/91=100% High Confidence in Reported Results	84/85=99% High Confidence in Reported Results
Interventions	
• Data sharing by direct EMR access • Year-round medical record review • Value based payment programs	• Member incentives • Provider education • Newsletters

Table 19: Well Care Visit for the Foster Care Population PIP

Well Care Visits for the Foster Care Population
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 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. For this PIP, there are several rates monitored. Those rates included three retired HEDIS measures and several active measures. The retired measures showed a decline in the Adolescent Well Care rate

Well Care Visits for the Foster Care Population	
(69.59% to 66.75%), and the Well Child in the First 15 months (6+ visits) (58.16% to 54.93%). The Well Child Visits in third, fourth, fifth, and sixth years of life increased from 83.38% to 83.68%. For the active measures, the W30 measure (Well Child Visits in the First 30 months of life (0 – 15 months) declined 58.16% to 54.93%. The W30 measure for the 15-30 months declined from 89.33% to 87.01%. The Well Child Visit for the for 3-11 years declined from 77.42% to 76.30%, for 12-17 years declined 76.02% to 72.22%. For ages 18-21, the measure improved 38.46% to 43.54%. The Total Well Child Visit rate declined 73.51% to 71.47%.	
Previous Validation Score	Current Validation Score
91/91=100% High Confidence in Reported Results	84/85=99% 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 • A texting campaign • The Take Flight Program • Member incentives

Table 20 lists the Recommendations Constellation Quality Health provided for the Diabetes Outcomes Measure and the Well Care Visits for the Foster Care Population PIPs.

Table 20: PIP Recommendations

PIP	Section	Reason	Recommendation
Diabetes Outcomes Measures	Was there any documented, quantitative improvement in processes or outcomes of care?	The results showed a slight decline in the HBA1C <8% measures from 42.82% to 42.09%. The Blood Pressure Control (<140/90) showed a decline in the latest remeasurement from 63.02% to 61.31%.	Continue to assess interventions and consider sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.
Well Care Visits for Foster Care Population	Was there any documented, quantitative improvement in processes or outcomes of care?	Those rates included three retired HEDIS measures and several active measures. The retired measures showed a decline in the Adolescent Well Care rate (69.59% to 66.75%), and the Well Child in the First 15 months (6+ visits) (58.16% to 54.93%). For the active measures, the W30 measure (Well Child Visits in the First 30 months of life (0 – 15 months) declined 58.16% to 54.93%. The W30 measure for the 15-30 months declined from 89.33% to 87.01%. The Well Child Visit for the for 3-11 years declined from 77.42% to 76.30%, for 12- 17 years declined 76.02% to 72.22%. The Total Well Child Visit rate declined 73.51% to 71.47%.	Continue interventions and assess impact of each intervention wherein possible.

Details of the validation of the PMs and PIPs can be found in the *Constellation Quality Health EQR Validation Worksheets, Attachment 3*.

For this EQR, Select Health met all the requirements in the QI section of the review as noted in *Figure 6*.

Figure 6: Quality Improvement Findings

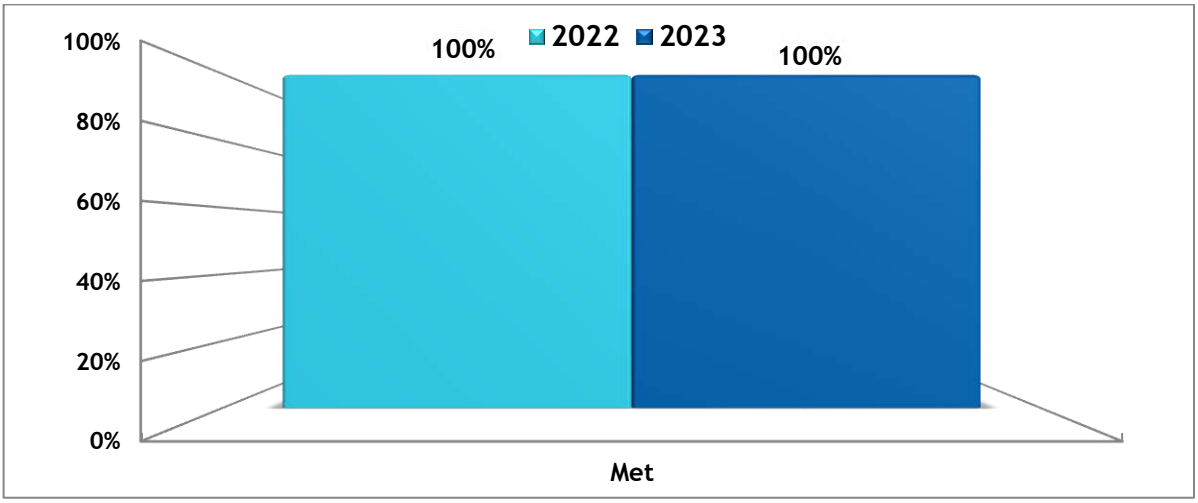


Table 21: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Select Health has a number of ongoing interventions to track and improve well care visits.	✓		
The Performance Measures were compliant with the HEDIS technical specifications for rate calculations.	✓		
All Performance Improvement Projects received validation scores within the High Confidence range.	✓		

Table 22: Quality Improvement
Weaknesses, Recommendations, or Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The Quality Clinical Care Committee did not meet at regular intervals as required by the committee's charter.	Recommendation: Ensure the Quality Clinical Care Committee meets at regular intervals as outlined in the committee charter.	✓		
The performance improvement projects showed declines in indicator rates.	Recommendation: Continue to assess the PIP interventions and assess the impact of each intervention wherein possible. Also, consider conducting a sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.	✓		

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Select Health provided the 2023 Quality Management Program Description for this EQR. This document was developed based on the health plan's 2022 performance and outcomes. The changes were outlined, and the goals and objectives were similar to the goals and objectives in 2022. The 2023 Quality Improvement Program Description was provided to the Quality Assessment Performance Improvement Committee and the Board of Directors for review and approval.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Monitoring and evaluating utilization of physical and behavioral services (including over- and underutilization and outliers) and the effectiveness of utilization management activities are included as part of the QI scope of work. The QI Program Description also included the potential measures that will be used to monitor over- and underutilization of services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Select Health develops a work plan annually to guide and track ongoing activities throughout the year. The 2022 and 2023 QI work plans were submitted for review. Both works plans contained the QI activities and objectives, timeframes for expected completion, responsible parties, and any ongoing monitoring notes. The work plans reflect the ongoing quality activities for the QAPI Committee, the Quality Clinical Care Committee, and the Quality of Service Committee. Each committee is responsible for the review and approval of their section of the work plan.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QAPI Committee oversees Select Health's quality, utilization, and population health management activities. This committee reports to the health plan's Board of Directors. The committee charter outlines the committee's primary responsibilities. The Quality Clinical Care Committee (QCCC) is a subcommittee of the QAPI Committee. The committee charter indicates this committee provides direction and oversight of the clinical quality and appeals, utilization management, behavioral health management, population health management, chronic care management, and the pharmacy programs.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Quality of Service Committee also reports to the QAPI Committee. This committee is responsible for assuring the performance and quality improvement activities related to Select Health's services are reviewed, coordinated, and effective.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Market President continues to serve as the chairperson for the QAPI Committee. Other members include the Chief Medical Officer, medical directors, and other senior leaders. Network provider specializing in pediatrics, family medicine, and psychiatry are included as voting members. Committee minutes for meetings held in October 2022, December 2022, February 2023, April 2023, and June 2023 were provided. A quorum was met for each meeting. There were two network providers that did not attend any meetings and were removed from the committee. One medical director also did not attend any of the meetings.
3. The QI Committee meets at regular quarterly intervals.	X					All committees met at regular intervals except the QCCC. This committee's charter indicates this committee meets at a minimum of three times per year. However, this committee only met once in 2022. Per Select Health, most of this committee's business was switched to the QAPI Committee due to the availability of the providers serving on the QCCC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure the Quality Clinical Care Committee meets at regular intervals as outlined in the committee charter.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					Select Health uses Inovalon, a certified software organization, for calculation of HEDIS rates. Rates were audited by Healthcare Data Company, LLC. Constellation reviewed the rates for any substantial (>10%) rate changes from last year to this year. Counseling for Nutrition and Counseling for Physical Activity for Children declined by 10.89% and 12.35%, respectively. Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia declined 12.5%. In terms of year-over-year improvement, Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence, 30-day follow-up improved 12.15% from last year. The performance measure validation found that Select Health was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two Performance Improvement Projects (PIPs) were submitted for validation. Topics included Diabetes Outcomes and Well Care Visits for the Foster Care Population.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					The Diabetes Outcomes PIP showed a slight decline in the HBA1C measure (42.82% to 42.09%) and the Blood Pressure Control measure (63.02% to 61.31%). Some of the interventions included data sharing, year-round medical record review, value-based payments, member incentives, and provider education. For the Well Child Visits in the Foster Care Population PIP, there are several rates monitored. Those rates included three retired HEDIS measures and several active measures. The retired measures showed a decline in the Adolescent Well Care rate (69.59% to 66.75%), and the Well Child in the First 15 months (6+ visits) (58.16% to 54.93%). The Well Child Visits in third, fourth, fifth, and sixth years of life increased from 83.38% to 83.68%. For the active measures, the W30 measure (Well Child Visits in the first 30 months of life (0–15 months) declined 58.16% to 54.93%. The W30 measure for the 15-30 months declined from 89.33% to 87.01%. The Well Child Visit for the for 3-11 years declined from 77.42% to 76.30%, for 12-17 years

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						declined 76.02% to 72.22%. For ages 18–21, the measure improved 38.46% to 43.54%. The Total Well Child Visit rate declined 73.51% to 71.47%. Interventions included data sharing, care management calls to new members, monthly gaps in care reports, clinical rounds, weekly appointment reports, provider education, a texting campaign, the Taking Flight Program, and member incentives. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. *Recommendation: Continue to assess the PIP interventions and assess the impact of each intervention where possible. Also, consider conducting a sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					The QI Program Description provided an overview of the Primary Care Physician Report cards that provide direct feedback on the practitioner's performance. Each report card contains the practitioner's performance on key quality measures compared to a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						peer group within Select Heath's network. Additionally, PCPs can pull member-level dashboard reports to identify care gaps along with a list of up-to-date services for reference.
3. The MCO tracks provider compliance with						Per Policy QI 154.006, EPSDT/ Prevention and Screening Outreach, Select Health tracks and monitors members who have not received the recommended Early and Periodic Screening, Diagnostic, and Testing (EPSDT) services and immunizations. Providers are notified on a monthly basis of members who are due for services. Select Health also provides a dashboard report which shows members who have completed services and those with care gaps. Providers can login to the provider portal to access these reports as needed. Provider Account Executives and staff in the QI Department offer assistance to providers to help improve compliance with EPDST and immunization services. Select Health uses gift cards and other rewards to incentivize members for healthy behaviors.
3.1 Administering required immunizations;	X					
3.2 Performing EPSDTs/Well Child Visits.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The evaluation of the effectiveness of the QI Program is conducted annually. Select Health submitted the Quality Management Program Evaluation for Calendar Year 2022. This Program Evaluation included the results of all the activities conducted in 2022. The analysis for each activity was included as well as identified barriers and opportunities for improvements.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

E. Utilization Management

42 CFR § 438.114, 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)

Constellation Quality Health's review of Select Health's Utilization Management (UM) Program included Program Descriptions, relevant policies, medical necessity determination processes, the Member Handbook, the Provider Manual, and a sample of approval, denial, appeal, and care management files.

Select Health's Utilization Management Program Description outlines staff responsibilities and the scope and objectives for physical health and behavioral health services. PerformRx serves as the pharmacy benefit manager and provides pharmaceutical services to members. PerformRx's additional pharmacy network management responsibilities include maintaining and updating the Preferred Drug List.

Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. However, there was no information regarding when the negative PDL changes were published on the website as required by the *SCDHHS Contract*.

Policy UM.318S, Preferred Provider Program, indicates the Preferred Provider Program is designated for providers to have clinical review requirements waived and that Medical Directors conduct annual audits to determine provider eligibility. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented such as Contract Exceptions and Primary Care Physician Auto Assignment. Neither of the two processes are communicated to the provider or correspond with the described process outlined in Policy UM.318S, Preferred Provider Program.

Coverage and Authorization of Services

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

The Medical Director provides clinical oversight of the UM Program and responsibilities entail policy interpretation, Level II Reviews, committee chair participation, physician education, etc. The Behavioral Health Medical Director provides clinical oversight of behavioral health services that entails policy development, adverse benefit decision reviews, clinical consultations, etc. Lastly, the Pharmacy Director provides oversight of

the pharmacy program and responsibilities include clinical consultations and monitoring to maintain quality assurance of pharmacy services.

The UM Reviewers are licensed practitioners that perform initial medical necessity review determinations utilizing approved clinical criteria, such as the SCDHHS Provider Manuals, InterQual, NIA Radiology Guidelines, American Society of Addiction (ASAM), etc. Standard authorization requests are processed within 14 calendar days and urgent requests within 72 hours. Pharmacy UM decisions are processed within 24 hours and retrospective requests are processed within 30 calendar days.

Constellation Quality Health's review of a sample of approval files reflected that determinations were completed timely for standard and expedited requests. Also, approval notifications were provided to the member and provider the same day of the approval decision.

A review of the sample of denial files yielded that the denials were completed in a timely manner and the denial notices clearly described the reasoning for the adverse benefit decision according to contractual guidelines.

Quarterly and annually, Select Health conducts Inter-Rater Reliability (IRR) testing for physicians and non-physicians. The results of the quarterly testing showed the IRR scores exceeded the targeted goal.

Appeals

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

Select Health's appeals process, applicable definitions, and timelines are described in policy MMS.100, Member Grievances and Appeals Process, the Utilization Management Program Description, Provider Manual, Member Handbook, and website. Members, or authorized representatives with the member's consent, may file an appeal orally or in writing. Members may request assistance with filing the appeal by contacting Select Health. The timeframe for filing an appeal is noted as 60 calendar days from the date on the adverse benefit determination letter.

For the 2022 EQR, Constellation Quality Health identified issues related to appeals information in the health plan's Provider Manual and in the Expedited Appeal Request Denial letter template. During this EQR, it is noted that Select Health corrected the identified issues. Please see the table that follows that provides an overview of the previously identified deficiencies, Select Health's response, and the findings for the 2023 EQR.

Table 23: Previous Appeals Procedures QIP

Standard	2022 EQR Findings	2023 EQR Findings
V C. Appeals		
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: 1.2 The procedure for filing an appeal;	Policy MMS.100, Member Grievances and Appeals Process, and the UM Program Description address appeal filing procedures. Additionally, the Member Handbook, Provider Manual, and Select Health's website identify that members can call Member Services to request assistance in filing an appeal, which can be filed orally or in writing. However, there were two identified issues: •The Provider Manual stated that the receipt of an appeal is acknowledged in one business day, which is inconsistent with Policy MMS.100, Members Grievances and Appeals Process. This policy indicates that an appeal is acknowledged within five business days. During the Onsite, it was mentioned that one business day is an internal goal. •The Expedited Appeal Request Denial letter template states that "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 and the health plan 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 include the language that a written appeal is required within 30 calendar days of a verbal request. *Quality Improvement Plan: Update the Provider Manual to reflect that an acknowledgement letter is sent within five business days to align*	These deficiencies were corrected.

Standard	2022 EQR Findings	2023 EQR Findings
	with Policy MMS. 100, Members Grievances and Appeals Process. Revise the Expedited Appeal Request Denial Letter and remove the requirement that the appeal request must be received in writing.	
Select Health Response – SHSC have revised the provider manual as follows: On page 41, the Provide Manual language to state: Assistance is available to members throughout the appeal process at no cost to the member. Member advocates will provide written acknowledgment of receipt of an appeal, including appeals that are withdrawn, to the member and/or member's authorized representative within five business days. Revised the Expedited Appeal Request Denial letter to remove language regarding *the requirement that the appeal request must be received in writing*. See attached copy of the Provider Manual update that is in process and the revised expedited appeal letter.		

In the previous EQR, the review of the sample of appeal files reflected inconsistencies in processing standard and expedited appeal requests according to the health plan's policy and contractual standards. During this EQR, Constellation Quality Health noted that Select Health corrected those deficiencies; however, there were other issues noted. The table below displays the previously identified issues, Select Health's response, and the findings for the 2023 EQR.

Table 24: Previous Appeal File Review QIP

Standard	2022 EQR Findings	2023 EQR Findings
V C. Appeals		
2. The MCO applies the appeal policies and procedures as formulated.	Overall, the review of the sample of appeal files reflected that Select Health consistently processes standard and expedited appeal requests according to the guidelines in Policy MMS.100, Members Grievances and Appeals Process. However, in four files, the notifications sent to the members included incorrect information: •The Acknowledgement Letters for three expedited appeal files incorrectly indicated that that the appeals would be resolved in 30 days as opposed to 72 hours.	A review of the files for this EQR found some of these issues were resolved. However, further improvements are needed to ensure the appeals are processed according to policy.

Standard	2022 EQR Findings	2023 EQR Findings
	•In one file, the notice sent to the member incorrectly informed the member that the reasoning 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 never received. These files were discussed during the Onsite. 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 reviewed 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, and not a different team that isn't as involved in the Appeals process. This change will assist in preventing these administrative errors in the future. *Quality Improvement Plan: Ensure the correct acknowledgement and resolutions letters are sent to members. Consider developing a process to monitor or review letters before sending.*	
Select Health's Response: The SHSC appeal's department have created the following action plan to change their process, update documentation as applicable and re-educate their staff on the following: 1. Remind staff that Acknowledgment Letters will not be sent for expedited appeals.		

Standard	2022 EQR Findings	2023 EQR Findings
2. Verify letters on our SharePoint site to make sure the most current version is used. Instruct staff to delete any and all older versions of the letters. 3. The Administrative assistant will be responsible for checking each letter prior to being printed for mailing.		

The sample of appeal files reviewed found issues with seven files. The following is a summary of those issues.

- For one file, Select Health extended an expedited appeal request without notifying the member as required by the *SCDHHS Contract, Section 9.1.6.1.5* and Policy MMS.100, Member Grievances and Appeals Process. Also, the acknowledgement letter sent to the member incorrectly indicated that the appeal would be resolved within 30 days as opposed to the 14-day extension timeframe.
- The acknowledgement letter was not sent for one standard appeal and five expedited appeal requests. During the onsite, Select Health indicated a verbal acknowledgement is given for expedited appeal requests. However, Policy MMS, 100, Member Grievances and Appeals Process, Section IV, Expedited Appeals, indicates the Appeals Administrator will create and mail a member's acknowledgment letter.

Appeals are reviewed quarterly as outlined in Policy MMS 100, Member Grievance and Appeals Process, by the Quality of Services Committee. Meeting minutes confirm the review and approval of the summary and analysis of appeals.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

Select Health's Care Management Programs consists of various core components that entail wellness and prevention, member safety approaches, member transitional care, condition management, and complex care management.

Select Health provides integrated medical-behavioral health management based upon a Four Quadrant Clinical Integration Model that entails: Quadrant 1: Care Management with Behavioral Health experience, Quadrant 2: Care Management with strong Behavioral Health and Physical Health Experience, Quadrant 3: Care management with Strong Physical Health Experience, and Quadrant 4: On-Demand Care Management Rapid Response.

Select Health members are referred for case management services through various sources such as self-referrals, social determinants of health assessments, medical and behavioral health claims, discharge planner referrals, and many other referral sources.

Member experience is measured with select programs through analyzing member complaints and member feedback surveys that are conducted for members receiving Complex Care Management and Bright Start Services. Also, an annual review is conducted of the care management program. The survey results and comprehensive evaluation are presented to the Quality Assurance Performance Improvement Committee for approval.

Select Health's care management files indicate care management activities are conducted according to contractual standards.

As noted in *Figure 7 Utilization Management Comparative Results*, 93% of the standards received a "Met" score and 7% were scored as "Partially Met."

Figure 7: Utilization Management Comparative Results

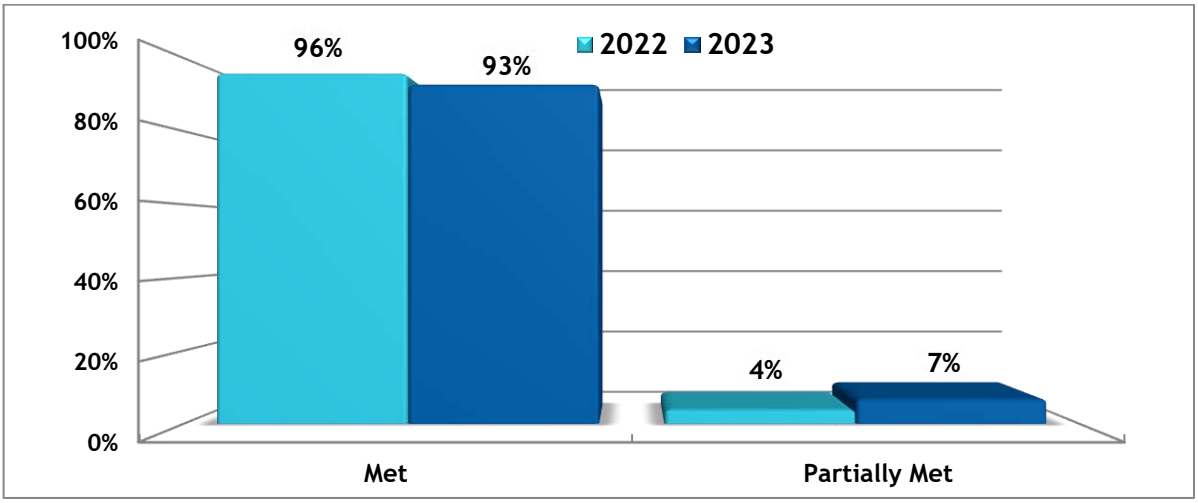


TABLE 25: Utilization Management Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
The Utilization Management Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: the mechanism to provide for a preferred provider program	Met	Partially Met
Medical Necessity Determinations	Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Partially Met
Appeals	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: The procedure for filing an appeal	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Table 26: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Select Health exceeded the target goal for Inter Rater Reliability Testing with results of 96% or greater.	✓		
Approval notifications were provided to the member and provider the same day of the approval decision.		✓	
Denial files were completed in a timely manner and clearly described the reasoning for the adverse benefit decision according to contractual guidelines.		✓	
The 2022 SHSC Utilization Management Program Evaluation indicated that the turnaround time (TAT) for behavioral health and non-behavioral health appeal reviews were all met timely.		✓	

Table 27: Utilization Management
Weaknesses, Recommendations, or Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Select Health's Policy UM.318S, Preferred Provider Program outlines the health plan's Preferred Provider Program. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented that allow providers to override submitting authorizations and auto member enrollment for high performing primary care providers. The two described processes that Select Health shared during onsite discussion do not coincide with the described process as outlined in Policy UM.318S, Preferred Provider Program or contractual regulations.	Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with *SCDHHS Contract, Section 8.5.2.8* and outlined in Policy UM.318S Preferred Provider Program.	✓		
Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. There was no information regarding when the negative PDL changes were published on the website. The health plan's changes notices of the PDL changes on the website did not appear to be updated 30 days prior to the effective date as required by contractual regulations.	Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Select Health's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*	✓		
The sample of appeal files reviewed found issues with seven files regarding the acknowledgement letters and failure to notify a member when the timeframe for resolution was extended.	Quality Improvement Plan: Ensure that acknowledgement letters are sent to members in accordance with Policy MMS.100, Member Grievances and Appeals Process. Develop a process to monitor a sample of appeal files to ensure all the requirements for processing appeals are met. Conduct a root-cause analysis when deficiencies are found so interventions can be developed to address the deficiencies.		✓	

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Select Health's Utilization Management (UM) Program Description outlines staff responsibilities, the scope, and objectives for physical health and behavioral health services. Also, PerformRx's UM Program Description provides a descriptive overview of the health plan's pharmacy program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					The UM Program Description provides an overview of the structure of the health plan's program. Also, Policy UM.008S, Clinical Criteria identifies that the UM reviewers utilize approved clinical criteria such as the SCDHHS Provider Manuals, InterQual, NIA Radiology Guidelines, American Society of Addiction (ASAM), etc. for determining medical necessity.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					As described in the UM Program Description and Policy UM.010S, Timeliness of UM Decisions, UM standard authorizations are processed within 14 calendar days and urgent requests within 72 hours. Pharmacy UM decisions are processed within 24 hours. Lastly, retrospective requests are processed within 30 calendar days as described in Policy UM.200, Post Service Review.
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.		X				Select Health's Policy UM.318S, Preferred Provider Program, indicated the Preferred Provider Program is designated for providers to have clinical review requirements waived and annually, Medical Directors conduct retrospective chart and claims audits for providers to maintain eligibility within the program. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented such as Contract Exceptions and Primary Care Physician Auto Assignment . Neither of these two processes are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						communicated to the providers for participation and do not correspond with the processes outlined in Policy UM.318S, Preferred Provider Program. *Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy UM.318S Preferred Provider Program.*
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Select Health's UM Program Description provides a descriptive overview of the roles and responsibilities of the Medical Director. The Medical Director's responsibilities include but are not limited to policy interpretation, Level II Reviews, committee chair participation, physician education, and consultation. Additionally, the Behavioral Health Medical Director provides clinical oversight of behavioral health services, including policy development, adverse benefit decision reviews, clinical consultations, etc. As described in the Pharmacy Program Description, the Pharmacy Director provides oversight of the pharmacy program and responsibilities include clinical consultations and monitoring to maintain quality assurance of pharmacy services.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and grievances and/or appeals related to medical necessity and coverage decisions.						
V B. Medical Necessity Determinations *42 CFR § 438.114, 42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation Quality Health's review of the sample of approval files reflected that the UM reviewers utilized clinical criteria consistency in performing UM determinations.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Review of the sample of approval files reflected that individualized clinical needs are taken into consideration and clinical consultations occurred appropriately as described in Policy UM.008S, Clinical Criteria.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Quarterly and annually, Select Health conducts Inter-Rater Reliability (IRR) testing for physicians and non-physicians. The projected benchmark goal is 90% and reviewers are required to take a refresher course and are placed on a Performance Improvement Plan if their individual goal is not met.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Based upon the quarterly testing, the overall IRR scores were above 96%, exceeding the target goal.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.		X				Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. There was no information regarding when the negative PDL changes were published on the website. The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3,* requires the health plan's Pharmacy & Therapeutics Committee to approve the PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plan's website at least 30 days prior to implementation. Select Health's changes posted on the website did not appear to meet this requirement. *Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Select Health's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy UM.095S, Emergency Room Services, describes emergency and post stabilization services. Emergency services are available at no cost to members.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the sample of approval files reflected that determinations were completed within 14 calendar days for standard requests and 72 hours for urgent requests. Also, approval notifications were provided to the member and provider the same day of the approval decision.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					UM denial files reflected that additional clinical information was requested appropriately prior to making an adverse benefit determination.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Constellation Quality Health's review of a sample of denial decisions yielded that the adverse benefit decisions were promptly communicated to providers and members. Additionally, the reason for the adverse benefit decision, process for filing an appeal, and the right to request a State Fair Hearing were indicated.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policies and procedures for filing an appeal are described in policy MMS.100, Member Grievances and Appeals Process, the 2023 SHSC Utilization Management Program Description, the Provider Manual, and the Member Handbook.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definition of an appeal is appropriately provided in the Member Handbook, Provider Manual, in policy, and on the website.
1.2 The procedure for filing an appeal;	X					Policy MMS.100, Member Grievances and Appeals Process, and the UM Program Description describe processes for filing an appeal. The Member Handbook, Provider Manual, and Select Health's

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						website instruct members or an authorized representative to call Member Services for assistance in filing an appeal, which can be filed orally or in writing.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					The 2023 UM Program Description states that "For expedited appeal request SHSC will resolve standard appeals as expeditiously as the Member's health conditions require but no more than within 72 hours from receipt of the request."
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					The appropriate acknowledgement, review, and resolution timelines are described in the Member Handbook and Provider Manual along with information on appeal extensions if needed.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				The sample of appeal files reviewed found issues with seven files.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• For one file, Select Health extended an expedited appeal request without notifying the member as required by the *SCDHHS Contract, Section 9.1.6.1.5* and Policy MMS.100, Member Grievances and Appeals Process. Also, the acknowledgement letter sent to the member incorrectly indicated that the appeal would be resolved within 30 days as opposed to the 14-day extension timeframe. The reason for the extension was not documented in the appeal notes reviewed or conveyed to the member. • The acknowledgement letter was not sent for one standard appeal and five expedited appeal requests. During the onsite, Select Health indicated a verbal acknowledgement is given for expedited appeal requests. However, Policy MMS, 100, Member Grievances and Appeals Process, Section IV, Expedited Appeals, indicates the Appeals Administrator will create and mail a member's acknowledgment letter. *Quality Improvement Plan: Ensure that acknowledgement letters are sent to members in accordance with Policy MMS.100, Member Grievances and Appeals Process. Develop a process to monitor a sample of appeal files to ensure all the requirements for processing appeals are met. Conduct a root-cause analysis when*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						deficiencies are found so interventions can be developed to address the deficiencies.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Quality of Services Committee meeting minutes on November 30, 2022, and June 7, 2023, confirm the review and approval of the summary and analysis of appeals. Policy MMS.100 Member Grievance and Appeals Process, describes that a quarterly summary of member appeals is reported to the Quality of Services Committee.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					A descriptive overview of Select Health's Care Management Program is outlined in the Population Health Management Program Description and Policy PH-CC 301S, MCO Transition Coordinator. The program consists of various core components that entail wellness and prevention, member safety management, transitional care, and complex care management.
2. The MCO has processes to identify members who may benefit from care management.	X					Select Health members are referred for case management services through various sources such as self-referrals, social determinants of health assessments, medical and behavioral health claims,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discharge planner referrals, and many other referral sources.
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					Select Health provides integrated medical-behavioral health management based upon a Four Quadrant Clinical Integration Model that entails: Quadrant 1: Care Management with Behavioral Health experience (member with high behavioral needs), Quadrant 2: Care Management with strong Behavioral Health and Physical Health Experience (member with high physical and behavioral health needs), Quadrant 3: Care management with Strong Physical Health Experience (member with high physical needs and low behavioral health needs), and Quadrant 4: On-Demand Care Management Rapid Response (members with low behavioral health and physical needs).
6. Care Transitions activities include all contractually required components.						
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					Select Health's policies Policy UM. 706S, Continuity of Care, Policy PH-CC 301S Transition Coordinator, Policy MEM 129.117, Termination of Primary Care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider, and the Population Health Management Program Description describe the transitional care process and requirements for managing transitions of care for new members, pregnant members, members who are receiving inpatient treatment at the time of enrollment, etc. across healthcare settings.
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					Select Health measures member experience by analyzing member complaints and conducting special program member feedback surveys for members receiving Complex Care Management and Bright Start Services. Also, an annual review is conducted to assess the program goals, structures, and effectiveness of the care management program. The survey results and comprehensive evaluation are presented to the Quality Assurance Performance Improvement Committee for approval.
8. Care management and coordination activities are conducted as required.	X					Select Health's care management files indicate that care management activities are conducted as required, including conducting care management assessments, treatment planning, follow up, and linkage to appropriate community resources.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

F. Delegation

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

Select Health delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include credentialing, utilization management, and the nurse call line.

For this review, Select Health reported 15 delegation agreements, as shown in *Table 28: Delegated Entities and Services*.

Table 28: Delegated Entities and Services

Delegated Entities	Delegated Services
National Imaging Associates (NIA)	Radiology Utilization Management
BHM Health Solutions	Behavioral Health Decision Reviews on Assigned Cases
PerformRx	Pharmacy
Infomedia Group dba Carenet Health Solutions	24/7 Nurse Triage Line
AnMed Health AU Medical Center Health Network Solutions (HNS) Lexington Health, Inc. Medical University of South Carolina (MUSC) Prisma Health PSG Delegated Services Regional Health Plus (RHP) Roper St. Francis (RSF) Self Regional Healthcare St. Francis Physician Services (SFPS)	Credentialing/Recredentialing

All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, and Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, describe processes for delegation of health plan activities and oversight of delegated entities. All potential delegates are subjected to a pre-delegation assessment to determine their capabilities for conducting functions in compliance with all requirements. Annual oversight and ongoing monitoring are conducted for each delegate by AmeriHealth Caritas and/or Select Health. Standardized audit tools specific to functional areas are

used for pre-delegation and annual assessments and are compliant with contractual and other performance standards.

Documentation of annual oversight was provided for all delegated entities. The annual oversight documentation included any deficiencies found during the annual evaluation, recommendations for improvement, and corrective action as needed.

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

Figure 8: Delegation Findings

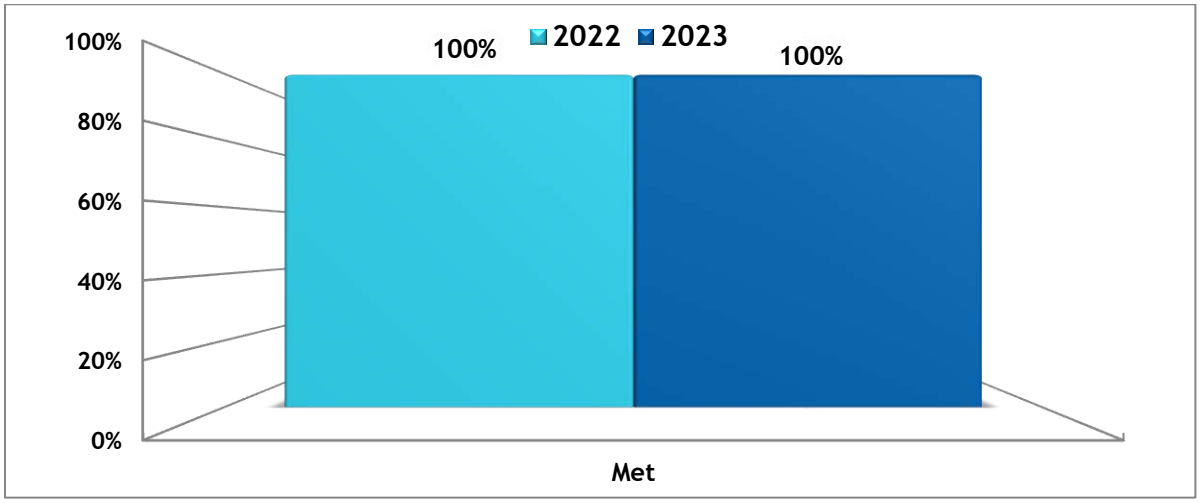


Table 29: Delegation Services Strengths

Strengths	Quality	Timeliness	Access to Care
All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process.	✓		
The annual oversight documentation included any deficiencies found during the annual evaluation, recommendations for improvement, and corrective action as needed.	✓		

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Select Health delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include credentialing, utilization management, and the nurse call line. All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, and Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, describe processes for delegation of health plan activities and oversight of delegated entities. Documentation of annual oversight was provided for all delegated entities. The annual oversight documentation included any deficiencies found during the annual evaluation, recommendations for improvement, and corrective action as needed.

G. Mental Health Parity

The Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008 requires health plans to cover behavioral health/substance use disorder and medical/surgical benefits equally. Constellation Quality Health conducted a Mental Health Parity assessment to determine if Select Health met the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment was conducted as a two-step process. Step one involved assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assessed the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits.

Select Health provided their Program Descriptions, various utilization and network access reports, Member and Provider Handbooks, a benefit map, NQTL list and comparison charts, and the QTL list and assessment tools. This information was used to determine overall compliance with the Federal Parity Act. The following is a summary of this assessment.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to Select Health to complete for the Mental Health Parity QTL assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information was used to determine if financial requirements and quantitative treatment limitations that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical-surgical (medical/surgical) benefits. The QTL assessment results are displayed in *Table 30: Quantitative Treatment Limitations Assessment*.

Table 30: Quantitative Treatment Limitations Assessment

Classification	Substantially All Categories Identified	*Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
Inpatient	Y	Copay $25.00	Accepted
Outpatient	Y	Copay $3.30	Accepted
Pharmacy	Y	Copay $3.40	Accepted
Emergency Services	N/A	N/A	N/A

**Highest level that can be applied/or minimum limit that can be applied.*
Note. Out of Network services are not covered, and thus, were not examined. There is no copay or session limit for Emergency Services.

Overall, the assessment found the mental health services are aligned with the medical/surgical financial and treatment limitations and Select Health met the requirements for Mental Health Parity for the QTLs.

Mental Health Parity Non-Quantitative Treatment Limitations (NQTL) Assessment

Constellation Quality Health reviewed Select Health's supporting documents to assess both elements of NQTL Parity: Comparability and Stringency. Compliance with these two factors depends on a parity of process, policy, and practice.

Review Criteria – Select Health uses InterQual as their Medical and Behavioral Health criteria. ASAM is used for substance use disorder, with no use of internally developed criteria.

Clinical Auditing – IRR is conducted by the corporate team, which selects case studies from each benefit category.

Appeals and Denials – Select Health's denial rate for Mental Health/Substance Use Disorder (MH/SUD) is higher than the rate for medical benefits. By examining appeal overturn rates between medical appeals and MH/SUD appeals, Constellation Quality Health can make an inference about stringency. If the appeal overturn rates are higher for MH/SUD, as they are for medical benefits, it could mean that criteria are being applied more stringently. A deeper dive into the appeal data should be performed to assess administrative necessity compared to medical necessity. Administrative necessity would indicate a discrepancy in comparability while medical necessity would indicate a discrepancy in stringency.

Provider Network – Select Health's Behavioral Health network is robust. Any gaps are in rural areas where demand for services exceeds available practitioners. One way to assess network adequacy is to look at the demand for out-of-network services and how many adverse decisions were appealed. The chart below illustrates fewer mental health appeals than medical/surgical appeals, demonstrating compliance with parity in this area.

Out of Network Service Appeals CY 2022						
Medicaid HMO	Overturned				Upheld	
	Total Number of Out of Network Service appeals	Total Number of Out of Network Service appeals per 1,000 members	Goal	Goal Met?	Total Number of Out of Network Service appeals	Total Number of Out of Network Service appeals per 1,000 members
Non-Behavioral Health	26	0.06	<5	Yes	26	0.06
Behavioral Health	5	0.01	<5	Yes	10	0.02

The ECHO survey results shown in the table below reflect a responsive network development program, with an 11.3% increase in member's self-reported ability to find a good behavioral health provider.

Experience of Care and Behavioral Health Outcomes (ECHO) Survey Results						
Survey Question	2020 Survey Response N=165	2021 Survey Response N=122	2022 Survey Response N=105	2022 Goal	Increase/Decrease	Goal Met?
Q43: Able to find a good provider	64.4%	56.4%	67.7%	75%	+11.3%	No
Q46: Getting counseling or treatment as needed	80.3%	78.4%	82.9%	75%	+4.5%	Yes

Select Health has the tools, plans, and interventions to support the goal of Parity. The NQTL assessment found the mental health services comply with Parity requirements of comparability and stringency.

Select Health met all the requirements for the Mental Health Parity Assessment as shown in the figure that follows.

Figure 9: Mental Health Parity Assessment Results

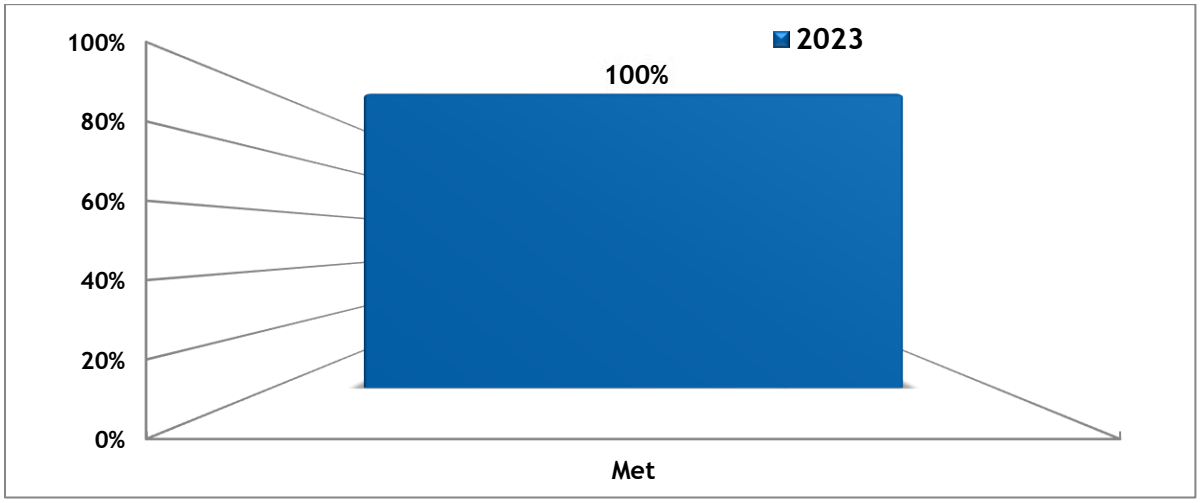


Table 31: Mental Health Parity Strengths

Strengths	Quality	Timeliness	Access to Care
Mental Health Parity assessment showed mental health services are aligned with medical surgical financial and treatment limitations.			✓
Mental Health Parity assessment showed mental health services are aligned with medical surgical financial and treatment limitations.			✓

Strengths	Quality	Timeliness	Access to Care
Access and availability parity is achieved; Provider Network analysis and implementation plans are robust and responsive down to the local level.			✓
Utilization Management Criteria and Processes achieve parity.			✓
IRR incorporates both MH/SUD and Medical/Surgical cases.			✓

Table 32: Mental Health Parity Weakness and Recommendation

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The analysis of denials and appeals was incomplete. While Z scores were displayed for MH/SUD and MS, Constellation was unable to determine the denominator used, and was thus unable to compare overturned appeals/K for MH/SUD and overturned appeals/K for MS. A further breakdown of administrative appeals vs. clinical appeals would help determine, if any problems are noted, whether the problem is with consistency or stringency.	Recommendation: Analysis of administrative and medical necessity appeals separately to tease out the root cause of any identified differences between MH/SUD and MS comparability and stringency. Expressing the rates per thousand will help with this.			✓

VII. MENTAL HEALTH PARITY

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. MENTAL HEATLH PARITY						
1. The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations.	X					Constellation Quality Health reviewed Select Health's supporting documents to assess both elements of NQTL Parity: Comparability and Stringency. Compliance with these two factors depends on a parity of process, policy, and practice. Select Health has the tools, plans, and interventions to support the goal of Parity. The NQTL assessment found the mental health services comply with Parity requirements of comparability and stringency. The analysis of denials and appeals was incomplete. While Z scores were displayed for MH/SUD and MS, Constellation was unable to determine the denominator used, and was thus unable to compare overturned appeals per 1,000 for MH/SUD and overturned appeals per 1,000 for Medical/Surgical. A further breakdown of administrative appeals compared to clinical appeals would help determine if any problems are noted and whether the problem is with consistency or stringency.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Analysis of administrative and medical necessity appeals separately to tease out the root cause of any identified differences between MH/SUD and Medical/Surgical comparability and stringency. Expressing the rates per thousand will help with this.
2. The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	X					Two templates were provided to Select Health to complete for the Mental Health Parity Quantitative Treatment Limitations assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information was used to determine if financial requirements and quantitative treatment limitations that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical-surgical (medical/surgical) benefits.

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets

Attachment 1: Initial Notice and Materials Requested for Desk Review

July 31, 2023

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

Dear Ms. Thompson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2023 External Quality Review (EQR) of Select Health of South Carolina (Select Health) is being initiated. An external quality review (EQR) conducted by Constellation Quality Health, formally The Carolinas Center for Medical Excellence, is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by Constellation Quality Health to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review, onsite visit and will address all contractually required services as well as follow-up of any areas of weakness identified during the previous review. The Constellation Quality Health EQR team plans to conduct the virtual onsite on **September 20th** and **21st.** In preparation for the desk review, the items on the enclosed desk materials list should be provided to Constellation Quality Health no later than **August 14, 2023.**

To help with submission of the desk materials, we have set up a secure file transfer site to allow health plans under review to submit desk materials directly to Constellation Quality Health through the site. The file transfer site can be found at: https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Project Manager, External Quality Review

cc: SCDHHS

August 4, 2023

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

Dear Ms. Thompson:

The Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008 requires health plans to cover behavioral health/substance use disorder and medical/surgical benefits equally. The South Carolina Department of Health and Human Services (SCDHHS) has contracted with Constellation Quality Health, formally The Carolinas Center for Medical Excellence, to conduct a Mental Health Parity assessment to determine if the Health Plans in SC meet the Mental Health Parity requirements outlined in the Federal Parity Act.

In order to complete this assessment, Constellation Quality Health is requesting that your organization provide the following information by August 18th, 2023.

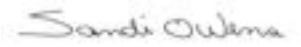
1. Program Descriptions	
	Utilization Management
	Mental Health/Substance Use Disorder (MH/SUD)
	Medical/Surgical (MS)
	Quality
2. Reports	
	M/S Denial - denial rates, administrative and clinical (IP, OP, ER, RX)
	M/S Appeal – overturn rates (IP, OP, ER, RX)
	M/S Pharmacy Denials - -denial rates, administrative and clinical (IP, OP, ER, RX)
	M/S Pharmacy Appeals - -overturn rates (IP, OP, ER, RX)
	MH/SUD Denials- denial rates, administrative and clinical (IP, OP, ER, RX)
	MH/SUD Appeals - overturn rates (IP, OP, ER, RX)
	Authorization Report
	Out of Network Utilization (M/S)
	Out of Network Utilization (MH/SUD)
	Network Access Reports (M/S)
	Network Access reports (MH/SUD)
3. Handbooks/Manuals	
	Provider Manual
	Member Handbook
	Benefit Documents
4. Parity Documents	
	Benefit Map (Appendix B)
	NQTL List (Appendix C)
	NQTL Comparison Chart (Appendix D)
	QTL List (Appendix E)
	QTL Tool (Excel Spreadsheets)

Please note, this information should be uploaded to Constellation Quality Health's secure file transfer site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

An opportunity for a conference call with your staff to describe the review process and answer any questions is being offered. Please contact me at sowens@constellationqh.org if you would like to schedule a conference call.

Sincerely,



Sandi Owens, LPN
Project Manager, External Quality Review

Enclosure
cc: SCDHHS

Attachment 2: Materials Requested for Onsite Review

External Quality Review 2023/2024

MATERIALS REQUESTED FOR DESK REVIEW

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

2. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, and key managers responsible for the functions. For all staff required in the SCDHHS Contract, Section 2, Exhibit 1 and Exhibit 2, indicate whether the staff are in-state, the number of FTEs, and any required designations. For contractually required key positions, provide the portion of time allocated to each Medicaid contract as well as all other lines of business.

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

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base. Please include the following:
    a. Geographic access assessments
    b. Network development plans
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios (PCP and specialist)
    f. Analysis of in-network and out-of-network utilization data
    g. Provider identified limitations on panel size considered in the network assessment

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

Excel Spreadsheet Format

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

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

7. A completed Provider Network File Questionnaire.

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

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

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

11. The Quality Improvement work plans for 2022 and 2023.

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

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

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

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

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

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

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

19. A complete list of all members enrolled in the case management program from September 2022 through July 2023. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

20. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for September 2022 to July 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of September 2022 through July 2023.

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

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

    . Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    a. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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

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

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

30. A copy of the provider handbook or manual.

31. A sample provider contract.

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

h. A copy of the policies or program description that address the information systems security and access management. Please also include policies with respect to email and PHI.
i. A copy of the Information Security Plan & Security Risk Assessment.

33. Provide a listing of all delegates conducting delegated activities for the Medicaid program. Please include both local health plan delegates and corporate delegates that conduct activities for South Carolina using the following format:

Date of initial Delegation	Name of Delegated Entity	Functions Delegated	Methods of Oversight

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

35. Results of the most recent annual evaluation and ongoing monitoring activities for all delegated entities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.
36. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    a. final HEDIS audit report
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen; hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;
    c. reporting frequency and format;
    d. specifications for all components used to identify the eligible population (e.g., member ID, age, sex, continuous enrollment calculation, clinical ICD/CPT codes, member months/years calculation, other specified parameters);
    e. programming specifications that include data sources such as files/databases and fields with definitions, programming logic and computer source codes;
    f. denominator calculations methodology, including:
        1) data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the denominator;
    g. numerator calculations methodology, including:
        1) data sources used to calculate the numerator (e.g., claims files, medical records, provider files, pharmacy files, enrollment files, etc.);
        2) specifications for all components used to identify the population for the numerator;
    h. calculated and reported rates.
    i. Please include the point value, and index scores for the SCDHHS withhold measures.

37. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;

iii. Two specialists;
iv. Two behavioral health providers;
v. Two network hospitals; and
vi. One file for each additional type of facility in the network.

b. Recredentialing files for:
   i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
   ii. Two OB/GYNs;
   iii. Two specialists;
   iv. Two behavioral health providers
   v. Two network hospitals; and
   vi. One file for each additional type of facility in the network.
c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of September 2022 through July 2023. Include any medical information and physician review documentation used in making the denial determination.
d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of September 2022 through July 2023, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

- **should be organized and uploaded to the secure Constellation Quality Health's EQR File Transfer site at:**
  https://egro.thecarolinascenter.org

Attachment 3: EQR Validation Worksheets

EQR Network Adequacy Validation Worksheet

EQR NETWORK ADEQUACY VALIDATION WORKSHEET	
Plan Name:	Select Health
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	Score	Comments
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the MCO to the EQRO? (1)	MET	Data sources for appropriate timepoints were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? (1)	MET	All variables were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? (1)	MET	Missing data was addressed.
1.4 Do the MCO's data enable valid, reliable, and timely calculations of the indicators? (1)	MET	Data allowed valid and reliable calculations.
1.5 Did the MCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? (1)	MET	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the MCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? (1)	MET	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? (1)	MET	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? (1)	NA	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the MCO include appropriate calculations and sound methodology? (5)	MET	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
2.1 Are the methods selected by the MCO appropriate for the state? (10)	MET	Methods aligned with State standards.
2.2 Are the methods selected by the MCO appropriate to the state Medicaid and CHIP population(s)? (10)	MET	Methods aligned with populations.
2.3 Are the methods selected by the MCO adequate to generate the data needed to calculate the indicators according to the State's expectations? (10)	MET	Methods generated required data for NA assessment.
2.4 Does the MCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? (1)	MET	Provider network file questionnaire indicated appropriate provider classification.
2.5 If the MCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? (1)	MET	Sound sampling methods were applied, wherein necessary.
2.6 If the MCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? (1)	MET	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. (1)	MET	Random sampling was utilized wherein required.
2.8 Does the MCO's approach for measuring time/distance indicators match the state's expectation? (1)	MET	Approach for time/distance aligned with State requirements.
2.9 Does the MCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? (1)	MET	Ratio calculations were conducted according to State requirements.
2.10 Does the MCO's approach for determining the maximum wait time for an appointment match the state's expectation? (1)	MET	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? (10)	MET	Methods are objective and use of third-party vendors were used wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? (10)	MET	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF MCO NETWORK ADEQUACY RESULTS		
Component / Standard (Total Points)	Score	Comments
3.1 Did the MCO produce valid results? (10)	MET	Results were judged to be valid.
3.2 Did the MCO produce accurate results? (10)	MET	Results were judged to be accurate.

ACTIVITY 3: ASSESSMENT OF MCO NETWORK ADEQUACY RESULTS		
Component / Standard (Total Points)	Score	Comments
3.3 Did the MCO produce reliable and consistent results? (10)	MET	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the MCO accurately interpret its results? (10)	MET	Findings were interpreted and analyzed by MCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

	Points Possible	Points Earned
Activity 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	NA	NA
1.9	5	5
Activity 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Activity 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	99	99

Points Earned	99
Possible Score	99
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR PIP Validation Worksheet

EQR PIP Validation Worksheet	
Plan Name:	Select Health
Name of PIP:	Well-Care Visits for Foster Care Members
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee care needs as stated on page 1.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	HEDIS Hybrid methodology was utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	MET	HEDIS Hybrid methodology was utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	MET	HEDIS Hybrid methodology was utilized.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are HbA1C<8 and BP control <140/90.
5.2 Did the indicators measure changes in health status, functional status enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure changes in processes of care and health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to hybrid methods
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel that are involved in the data collection and their qualifications are mentioned.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements are documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	There are three retired HEDIs measures, including AWC, W15, and W34. The Adolescent well care rate declined from 69.59% to 66.75%. The Well child in the first 15 months (6+ visits) declined from 58.16% to 54.93%. The Well child visits in 3rd, 4th ,5th, and 6th years of life increased from 83.38% to 83.68%. .For the active measures, W30 measure (Well child visits in the first 30 months of life (0 – 15 months) declined 58.16% to 54.93%. The W30 for 15-30 months declined from 89.33% to 87.01%. WCV for 3-11 years declined from 77.42% to 76.30%. for 12- 17 years declined 76.02% to 72.22%. For ages 18-21, it improved 38.46% to 43.54%. The total WCV rate declined 73.51% to 71.47%. Most rates declined from the previous measurement, with only 18–21-year-olds showing improvement in well care visit rates. *Recommendations: Continue interventions and assess impact of each intervention wherein possible.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Unable to judge as improvement was not reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	84
Project Possible Score	85
Project Rating Score	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR PIP Validation Worksheet

EQR PIP Validation Worksheet	
Plan Name:	Select Health
Name of PIP:	Comprehensive Diabetes Care
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee care needs as stated on page 1.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	HEDIS Hybrid methodology was utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	MET	HEDIS Hybrid methodology was utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	MET	HEDIS Hybrid methodology was utilized.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are HbA1C<8 and BP control <140/90.
5.2 Did the indicators measure changes in health status, functional status, enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure changes in processes of care and health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to hybrid methods
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel that are involved in the data collection and their qualifications are mentioned.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements are documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	The results showed a slight decline in the HBA1C <8% measures from 42.82% to 42.09%. The Blood Pressure Control (<140/90) showed a declined from 63.02% to 61.31%. *Recommendation: Continue to assess interventions and* consider sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Unable to judge as improvement was not reported.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	84
Project Possible Score	85
Project Rating Score	99%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR PM Validation Worksheet

EQR Performance Measure Validation Worksheet	
Plan Name:	Select Health
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2022
Review Performed:	2023

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2022 Volume 2 Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	Met	Denominator sources were accurate.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	Met	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	Met	Integration methods were found to be compliant.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	Met	Methods were reported to be compliant.

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

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

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	Select Health
Survey Validated	CAHPS MEMBER SATISFACTION- ADULT
Validation Period	2022
Review Performed	2023

Review Instructions
Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

Survey Element		Element Met / Not Met	Comments and Documentation
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

Survey Element		Element Met / Not Met	Comments and Documentation
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For MY2022, adult response rate was 13.2% (223 out of 1690) which is a slight decline from last year's response rate of 13.4%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022 *Recommendation: Determine if additional practices can be put in place to improve response rates for the Adult population.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	Select Health
Survey Validated	CAHPS MEMBER SATISFACTION- CHILD
Validation Period	2022
Review Performed	2023

Review Instructions
Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child response rate was 16.7% (400 out of 2,392 surveys) which is an increase over last year's rate of 13.7%. However, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CAHPS Report MY2022

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	Select Health
Survey Validated	CAHPS MEMBER SATISFACTION- CHILD (CCC)
Validation Period	2022
Review Performed	2023

Review Instructions
Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity.

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey CCC CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey CCC CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey CCC CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Child with CCC response rate was 16% (264 out of 1645), which is an improvement over the previous year's rate of 12.8%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey CCC CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey CCC CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey CCC CAHPS Report MY2022