Constellation Quality Health

South Carolina External Quality Review

Comprehensive Technical Report for Contract Year ' 23 – 24

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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*. To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) contracted with Constellation Quality Health, formerly The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all managed care organizations (MCOs) participating in the Healthy Connections Choices and/or Healthy Connections Prime Programs. The MCOs, also referred to as health plans, for the Healthy Connections Choices Programs include:

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

For the Healthy Connections Prime Programs, the MCOs include:

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

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

The purpose of EQRs is to ensure that Medicaid enrollees receive quality health care through a system that promotes quality, timeliness, accessibility, and coordination of all services. This report is a compilation of the findings of the annual reviews completed during the 2023-2024 EQR contract year.

The process Constellation Quality Health used for the EQRs is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for the review of Medicaid MCOs. The reviews included a desk review of documents; a virtual onsite visit; a Telephonic Provider Access Study; compliance review; mental health parity assessment; and validation of performance improvement projects (PIPs), performance measures (PMs), network adequacy, and satisfaction surveys.

For this contract year, Constellation Quality Health also conducted a Foster Care quality of care study. Results of that study were reported to SCDHHS in a separate report.

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 the MCO'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:

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation
- Mental Health Parity

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

Administration

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

Appropriate processes are followed for policy development, management, and ongoing review and revision. Staff are educated about new and revised policies.

Organizational Charts display operational relationships of staff, key positions, temporary personnel, shared services staff, vacant positions, etc. Four of the MCOs are compliant with requirements for key personnel. However, for the second consecutive year, Humana is not in compliance with contractual requirements for the Member Services Manager position.

Compliance and Fraud, Waste and Abuse (FWA) Plans, codes of conduct, and policies document compliance and business conduct expectations and processes for preventing, detecting, and responding to fraud, waste, and abuse. Issues were identified with ATC's and Humana's documentation of processes for conducting exclusion status monitoring. Compliance Committees assist in the implementation and oversight of the MCOs' Compliance Programs. Humana's current Compliance Committee is a corporate committee, but a health plan Compliance Committee is being established.

Pharmacy Lock-In Programs are established to manage inappropriate use of pharmacy benefits. No issues were noted for ATC, Healthy Blue, Molina, and Select Health. For Humana, issues were noted related to appeals of inclusion in the lock-in program, the 72-hour emergency supply of medication, and the process for notifying members are removed from the program.

The health plans have established processes to ensure confidentiality of protected information and include information about confidentiality in compliance training, policies, codes of conduct, etc.

The MCOs meet or exceed the claims processing timeliness requirements. Health plan information systems can accept and generate HIPAA-compliant transactions, meet security requirements, and can support required reporting to the State. Processes for ensuring data security are in place, and risk assessments are conducted to ensure the integrity of these processes. The MCOs have disaster recovery plans and business continuity plans.

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

Health plan policies, procedures, and program descriptions address initial and ongoing credentialing processes. However, ATC and Healthy Blue did not address all requirements for organizational providers. Credentialing Committees are chaired by Chief Medical Officers and Medical Directors. Recommendations were offered for Healthy Blue, Humana, and Molina to increase the variety of specialty providers on their committees and for Healthy Blue to reinforce

attendance expectations for committee members. Issues were noted in the samples of credentialing and recredentialing files for two of the five MCOs.

The health plans educate providers about health plan processes, and Provider Manuals and MCO websites reinforce the education. Healthy Blue's Provider Manual did not address all member benefits. Providers are educated about medical record documentation standards, monitored for compliance through routine medical record audits, and reeducated and reaudited when they do not meet the scoring thresholds. Providers are also monitored for continuity and coordination of care through medical record reviews, HEDIS measures, member satisfaction survey results, and more.

Network Adequacy Validation: The MCOs' provider networks were found to be adequate and consistent with the requirements of the CMS protocol, "Validation of Network Adequacy." The health plans assess network adequacy by conducting Geo Access mapping and monitoring member grievances, CAHPS results, and more. Policies define geographic access standards; however, ATC omitted some standards from its policy. Also, Select Health's Annual Network Development Plan included incorrect geographic access parameters, and Healthy Blue's Network Analyses for Driving Time and Driving Distance report did not include all required Status 1 provider types. Appointment access standards are documented in policies, but issues were identified with the information in Molina's policy, Provider Manual, and Member Handbook. Select Health's 2022 Network Development Plan listed an incorrect standard for routine new patient appointments. Provider compliance with appointment access standards is assessed through call studies while also considering member satisfaction survey results, grievances, out-of-network requests, etc.

The MCOs maintain print-version and online Provider Directories and validate provider information in the directories through call studies, outreach campaigns, credentialing processes, etc. Print versions of the MCOs' directories include the required information. ATC's online "Find a Provider" tool and Humana's online "Find a Doctor" tool did not include some contractually required language.

For each health plan, Constellation Quality Health conducted a Telephonic Provider Access Study focusing on primary care provider (PCP) access. The studies showed that overall provider access improved or was sustained for four of the five plans. The percentage of providers accepting the plans ranged from 86% to 96%. Rates for providers accepting new Medicaid patients ranged from 58% to 85%.

Member Services

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

Each MCO emphasizes their commitment that all members are treated in a manner that acknowledges their rights and responsibilities by including notification steps in policy and

providing rights and responsibilities in Member Handbooks, Provider Manuals, welcome kits, and on health plan websites.

Each MCO provides written member materials in alternative formats and in consideration of special needs, disabilities, or for members whose English speaking and reading proficiency is limited. Member Handbooks and other member communications provide instructions for obtaining a copy of the Member Handbook annually.

The MCOs contract with a certified CAHPS survey vendor to conduct child and adult member satisfaction surveys. Results of the satisfaction surveys are presented internally to the appropriate quality committees and network providers. Committee meetings cover the analysis and implementation of interventions to improve member satisfaction.

Processes for filing and handling grievances are detailed in policies, Member Handbooks, Provider Manuals, and on each health plan's website. Timelines for grievance acknowledgment, resolution, and extensions, if needed, are clearly described. Grievances are logged and categorized appropriately. Trends are reported quarterly as reflected in the minutes of internal quality committees. Issues were identified with one of the five MCOs specific to member notification of the right to file a grievance if they disagree with the extension of resolution timeframes and the health plan closing grievances prematurely when additional information is needed.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

The Quality Improvement (QI) Programs developed by the MCOs focus on the health care and services their members receive and include all aspects of health care quality. Each health plan provided a copy of their QI Program Description. Information about the QI Program is shared with providers and members through each health plan's website and in Provider Manuals and Member Handbooks.

Annually, the health plans develop QI work plans to identify and track the planned QI activities. Two of the MCOs' work plans contained errors or were incomplete.

The MCOs have established QI committees charged with oversight of the QI Program. The QI committees act as oversight committees and receive regular reports from other departments and/or subcommittees that are accountable to the committee. Members of these committees include the health plans' Chief Medial Officers or Medical Directors, quality leads, senior managers, and other staff responsible for key functions within the organization. Participating network providers with a wide variety of specialties serve as voting members. Humana's QI Committee lacked network provider participation as required by the *SCDHHS Contract*. This was an issue identified during the 2022 and 2023 EQRs and not corrected.

Minutes are documented for each meeting and presented to the committee for review and approval at the next scheduled meeting. Constellation Quality Health found issues with Humana's QI Committee meeting minutes.

An annual review of the overall effectiveness of the QI Program is conducted by each MCO. The results of the annual evaluations are used to develop and prioritize the next year's activities. ATC, Healthy Blue, Humana, and Select Health submitted the 2022 QI Program Evaluations and Molina submitted the 2021 QI Program Evaluation. Each of the Program Evaluations contained the annual analysis of the QI Programs with barriers, interventions, and conclusions or recommendations for each activity. Humana's QI Program Evaluation was missing data or results, and incorrect goals were being measured. These were previously identified issues that were not corrected.

Performance Measure Validation: Constellation Quality Health conducted a validation review of the HEDIS measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. The Performance Measure (PM) Validation found that all of the health plans were fully compliant with all HEDIS measures and met the requirements.

Health plan rates were compared for the current review year to the previous year. Due to timing of the reviews, MY2021 data are presented for Healthy Blue and Molina, and MY2022 data are presented for ATC, Humana, and Select Health. *Table 1: HEDIS Measures with Substantial Increases or Decreases* highlights the HEDIS measures with substantial increases or decreases. Rates shown in green indicate a substantial improvement (>10%), and the rates shown in red indicate a substantial decline (>10%). All of the rates reported by the MCOs and the statewide averages are included in the Quality Improvement section of this report.

Table 1: HEDIS Measures with Substantial Increases or Decreases

Measure/Data Element	ATC (MY 2022)	Healthy Blue (MY 2021)	Humana (MY 2022)	Molina (MY 2021)	Select Health (MY 2022)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)					
Counseling for Nutrition	61.80%	65.45%	58.39%	58.88%	59.32%
Counseling for Physical Activity	57.42%	61.56%	55.96%	56.2%	57.06%
Childhood Immunization Status (cis)					
Pneumococcal Conjugate	69.83%	72.26%	37.50%	67.4%	73.24%
Influenza	30.17%	35.52%	6.25%	35.28%	33.09%
Combination #3	59.61%	62.04%	27.08%	58.88%	64.72%
Appropriate Testing for Children with Pharyngitis (cwp)					
Total	80.32%	75.74%	82.35%	71.59%	82.40%

Measure/Data Element	ATC (MY 2022)	Healthy Blue (MY 2021)	Humana (MY 2022)	Molina (MY 2021)	Select Health (MY 2022)
Controlling High Blood Pressure (cbp)	56.69%	54.74%	63.41%	59.85%	52.01%
Follow-Up Care for Children Prescribed ADHD Medication (add)					
Initiation Phase	46.10%	32.56%	50.00%*	34.48%	42.49%
Continuation and Maintenance (C&M) Phase	59.91%	48.12%	NR	45.5%	57.05%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)					
Total - 30-Day Follow-Up	34.97%	36.89%	40.00%*	36%	36.47%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)					
30-Day Follow-Up: Total	26.07%	17.73%	20.69%	16.25%	27.83%
Pharmacotherapy for Opioid Use Disorder (POD)					
Pharmacotherapy for Opioid Use Disorder (Total)	35.31%	38.35%	41.38%	52.55%	32.96%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	80.00%*	50.00%	NR	93.75%	58.33%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)					
Cholesterol Testing - Total	30.23%	38.22%	18.18%*	28.64%	37.05%
Blood glucose and Cholesterol Testing - Total	28.14%	35.99%	18.18%*	26.94%	34.05%
Use of Imaging Studies for Low Back Pain (lbp)	69.37%	54.67%	70.37%	68.69%	71.25%

*Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator, * denominator less than thirty (30)*

Performance Improvement Project Validation: The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. Each health plan is required to submit PIPs to Constellation Quality Health for review annually. 11 projects were validated for the health plans. Results of the validation and project status for each project are displayed in *Table 2: Results of the Validation of PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

Table 2: PIP Validation Results

Project	Validation Score	Status
ATC		
Hospital Readmission	80/80=100% High Confidence in Reported Results	The Hospital Readmissions PIP aims to reduce the annual rate of readmissions within 30 days for 18- to 64-year-old patients. This PIP has three measurement periods. The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge was 18.0%, which reduced to 16.2% in 2021, then to 15.5% in 2022. The rate has met the benchmark.

Project	Validation Score	Status
Adult Access to Preventive Health Care (AAP)	80/80=100% High Confidence in Reported Results	The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The PIP showed improvement in the rate from MY2020 at 77.28% to MY2021 at 78.18%. The benchmark is 81.97%.
Healthy Blue		
CAHPS – Customer Service	99/99=100% High Confidence in Reported Results	This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass. This PIP showed an improvement in the rate for the percentage of members rating customer service from 81.1% in MY 2020 to 83.8% in MY 2021. The documentation showed interventions addressing the response rate and the language barriers as well as customer service-related interventions.
Comprehensive Diabetes Care	99/99= 100% High Confidence in Reported Results	The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. The rate for poor control (HbA1C > or = 9) declined from 51.09% for baseline to 41.61% remeasurement one, which is improvement, as the goal is to lower the rate. The retinal eye exam rate increased from 35.52% at baseline to 35.77% at remeasurement one.
Humana		
Human Papillomavirus Vaccine (HPV)	80/80=100% High Confidence in Reported Results	The HPV vaccine PIP is aimed at increasing HPV vaccines among 9 to 13-year-olds. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the human papillomavirus (HPV) vaccines. The goal rate for this PIP is 36.5%. The Measure Year (MY) 2021 rate was 1.82% which improved to 3.85% for MY 2022 for the interim rate, with a final rate of 11.5%. This rate includes medical record, supplemental, and administrative data.
Prenatal and Postpartum (PPC)	80/80=100% High Confidence in Reported Results	The aim for the Prenatal and Postpartum PIP is to increase the rate of eligible women receiving timely prenatal and postpartum care. The purpose of this project is to align with state efforts of increasing postpartum compliance in South Carolina by 15% by 2026. There were low denominators for the baseline rates for MY 2021, with a rate of 100% for prenatal care (only three members included in the rate) and 0% for postpartum care (three members in the rate). For MY 2022 interim rates, the results showed 84.49% for prenatal care (goal is 85.4%) and 57.59% (goal is 77.37%) for postpartum care. The final HEDIS rate is noted, however, as 92.7% for prenatal care, and 72.06% for postpartum care. The final MY 2022 rates show that prenatal care is above the goal, and the final rate for postpartum care is below the goal but improving.
Molina		
Improving Encounters Acceptance Rates	79/79=100% High Confidence in Reported Results	The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from remeasurement one at 96.9% to

Project	Validation Score	Status
		remeasurement two at 97.3% (the refreshed rate shows 98.82%). The goal is 100%. The 837P rejection rate declined from 2.82% to 1.35%, which demonstrated improvement. The goal for this measure is 2%.
Immunizations for Adolescents Program	73/74=99% High Confidence in Reported Results	The Immunizations for Adolescents PIP examines adolescents 13 years of age with one dose of meningococcal vaccine, one tetanus, Tdap, and HPV by their 13th birthday. Molina chose this PIP to target rural and urban areas across SC to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV related cancers. The baseline rate was 28.95% with a slight decline in the administrative rate of 28.35%. The annual improvement goal for this PIP is 31.19%.
Child and Adolescent Well-Care Visits	73/74=99% High Confidence in Reported Results	The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% at the remeasurement one. The goal is 44.29% for the annual improvement.
Select Health		
Diabetes Outcomes Measures	84/85=99% High Confidence in Reported Results	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%).
Well Care Visits for the Foster Care Population	84/85=99% High Confidence in Reported Results	The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase compliance with well-care visits for children and adolescents in foster care. For this PIP, several rates are monitored. Those rates include 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% and declined 76.02% to 72.22% for 12-17 years. For ages 18-21, the measure improved 38.46% to 43.54%. The Total Well Child Visit rate declined 73.51% to 71.47%.

Utilization Management

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

Each of the health plans has appropriate program descriptions, policies, and guidelines assist staff in conducting Utilization Management (UM) functions. Health plan Medical Directors provide overall clinical oversight of the UM Programs, with Behavioral Health Medical Directors and Pharmacy Directors providing oversight of their respective programs.

Initial review determinations are made by licensed clinical staff utilizing approved clinical criteria. UM Program Descriptions and policies provide address UM determination timeliness requirements. Inconsistencies were identified within ATC's UM Program Description and policy regarding the timeframe for providers to notify ATC of a service authorization request.

The health plans provide information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) posted on their websites. The *SCDHHS Contract* requires that negative PDL changes are published on the health plans' websites at least 30 days prior to implementation. Select Health's PDL change document did not include information regarding when the negative PDL changes were published on the website.

The health plans offer a Preferred Provider Program for providers. However, issues were noted in that ATC did not include the identification and tracking of preferred provider status and did not have a process for making providers aware of the program and Select Health reported processes for contract exceptions and auto assignment that were not communicated to providers and did not correspond to the health plan's policy.

Constellation Quality Health's review of sample approval and denial files found that most of the files were processed according to requirements. However, Humana and ATC incorrectly informed members that a written appeal is required when an oral appeal request is submitted.

The MCO's Care Management programs are described in various documents. Member referrals for care management are obtained through various sources. Members are provided care management services based upon their appropriate risk level and identified needs. The sample care management files reviewed during the EQR demonstrated that care management activities are conducted as required. However, several of Molina's files did not include the date the Individualized Care Plan was created and did not include ongoing documentation of a follow-up schedule for members receiving care management services.

The MCOs define and describe processes for handling member appeals in policies, Member Handbooks, Provider Manuals, and websites. Appropriate timeframes for appeal acknowledgment, resolution, and extension, if needed, are documented consistently. Humana's policy and appeal acknowledgement letter did not address the requirement that a member may file a grievance if

they disagree with an extension of the appeal resolution timeframe. Molina's UM Program Description and two letter templates incorrectly stated that a written appeal request must be submitted after a verbal request. This issue was identified during the previous EQR and not corrected.

For the random sample of appeal files reviewed for each health plan, all were processed timely and included documentation of the review by an appropriately credentialed reviewer. Healthy Blue and Select Health's appeal file review found issues with the appeal acknowledgments letters and incorrect resolution timeframes when an extension was used.

Delegation

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

Each of the MCOs contracts with outside entities to conduct some health functions and activities. Policies address processes the health plans must follow to delegate these functions and activities to other entities. These processes include assessing the potential delegates' abilities to conduct the activities in compliance with contractual requirements and health plan standards, implementing written delegation agreements to specify the activities delegated, responsibilities of the delegate and the health plan, and conducting annual oversight and ongoing monitoring of approved delegates.

The review of the MCOs' delegate oversight documentation revealed no issues for Healthy Blue, Molina, and Select Health. ATC had issues related to reporting of delegation oversight as required by policy. Humana had issues related to policy documentation of requirements for sub-delegation, incorrectly indicating some credentialing elements as "not applicable," and not consistently checking admitting privileges when conducting credentialing delegation file review.

Mental Health Parity Assessment

Constellation Quality Health was required to conduct a Mental Health Parity assessment to determine if the MCOs met the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment is conducted as a two-step process. Step one involves 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 assesses the non-quantitative treatment limitations (NQTLs), such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limitations on the scope or duration of benefits. The Mental Health Parity assessment was conducted for Humana, and Select Health. ATC did not provide all the information needed to conduct the assessment. The Mental Health Parity assessment for Healthy Blue and Molina will be conducted in the 2024 EQRs.

The MCOs provided Program Descriptions, various utilization and network access reports, Member and Provider Handbooks, benefit maps, NQTL lists and comparison charts, and QTL lists and

assessment tools. This information was used to determine overall compliance with the Federal Parity Act. Overall, the assessment found the mental health services are aligned with the medical/surgical financial and treatment limitations for Humana and Select Health. Both health plans met the requirements for Mental Health Parity for the QTLs.

SC Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. Constellation Quality Health's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs.

Administration

Solutions is a subsidiary organization of Community Health Solutions of America (CHS). The organizational chart included the Executive Director/Medical Director, and a Medical Advisor for clinical consultation as needed. The oversight of care coordination is divided between the Upstate, Midlands, and Low Country regions. Explanations for overflow coverage, filled vacancies, and interim positions noted on the Organizational Chart were provided during onsite discussion. The personnel files reviewed found that monthly exclusion screenings and evidence of required auto insurance, driver's license, drug screening, and background checks was included.

The privacy and confidentiality of Solutions' member information is described in the Employee Handbook and addressed in training at the time of employment and annually, thereafter. Employees and members are informed of their right and responsibility to report instances or suspected violations of fraud, waste, and abuse. Reporting options are provided on the Solutions website and the Report Medicaid Fraud, Waste, and Abuse flyer.

Solutions has policies and processes in place for addressing data, systems, information security, and access management. Complying with SCDHHS' requirements for managing Protected Health Information. The policies included a history of reviews and changes indicating regular evaluation occurs.

Provider Services

Initial and ongoing provider education processes and topics are covered in policy; however, the policy incorrectly stated the frequency of provider education. Initial provider orientation is conducted within 30 days of contracting through face-to-face or virtual sessions. Routine provider education is conducted every three years at the time of the provider's recredentialing. Additional provider updates are provided at least annually. Solutions uses the Medically Complex Children Waiver Enhanced Provider Network Orientation document for initial provider education.

The Provider Manual is an additional resource for information providers need to operate within Solutions' network. Solutions' website provides brief information about the MCCW program, billing, reimbursement, use of Medicaid guidelines, and the SCDHHS Preferred Drug List, etc. The website also provides links to SCDHHS, the SCDHHS Provider Manuals, and forums to report FWA.

Quality Improvement

Solutions' Quality Improvement Program is described in the 2023 Strategic Quality Plan. Solutions' Chief Medical Officer maintains primary responsibility and oversight of the Quality Program. Solutions has two QI projects underway. Topics include the Annual Visit and Initial Monthly Summary Reports and the Enhanced Provider Network Programs Modifications. The Annual Visit and Initial Monthly Summary Reports project appeared to contain several measures or indicators. However, during the onsite discussion, Solutions noted that this project had one measure with multiple subset measures. Each subset measure did not have a specific goal. Solutions conducts a formal evaluation of the QI Program annually, which identifies program outcomes and accomplishments. Solutions provided the 2022 Quality and Performance Annual Report.

Care Coordination/Case Management

The structure, objectives, and processes for conducting care coordination/case management activities are outlined in the South Carolina Solutions Medically Complex Children Waiver Program Description and policies. Participants are provided with written materials along with information about local and state-wide resources, appeals and grievances, etc. Most of Solutions' participant materials are available in English and Spanish. However, there are a few participant materials that are only available in English. Translation services are available. Reassessments for participant qualifications have resumed and those who do not qualify are disenrolled from the program. The Disenrollment Notification Letter appeared to be outdated. A sample of participant files reviewed indicated that care management activities were conducted according to contractual requirements.

Coordinated and Integrated Care Organizations Annual Review

Constellation Quality Health conducted an EQR of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those plans include ATC, Molina, and Select Health. This review focused on network adequacy for home and community-based services (HCBS) and behavioral health providers, over- and underutilization, and care transitions.

Provider Network Adequacy

The CICOs are required by contract to maintain a network of Home and Community Based Service (HCBS) providers that is sufficient to provide all enrollees with access to a full range of covered services in each geographic area. The CICOs are also required to have a network of Behavioral Health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative standard. Select Health's HCBS provider network met the minimum requirements. Molina only had five counties that met the minimum requirements. Wellcare has one county that did not meet the minimum requirements. All of the CICOs maintained a sufficient network of behavioral health providers to provide all enrollees with access to covered services.

Evaluation of Over/Under Utilization

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

Care Transitions

Constellation Quality Health reviewed each CICO's Program Descriptions and policies related to care transitions. The CICOs were also required to submit a file of enrollees hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. The CICOs were directed to only include those enrollees readmitted with a diagnosis that met the definition of a potentially avoidable hospitalization, which were defined by SCDHHS as Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers. Based on the file received from each CICO, a random sample of files was requested for review. The review found the CICOs are not conducting the appropriate care transitions functions as required by the contract. Files lacked documentation of collaboration with the facility Case Manager or Discharger Planning staff and medication monitoring and showed untimely attempts to contact the member or caregiver to conduct the 72-hour follow-up.

Healthy Blue (Readiness Review)

At the request of SCDHHS, Constellation Quality Health conducted a readiness review for Healthy Blue, a new MCO providing services for the Healthy Connections population in SC. This review was to assess the preparedness of Healthy Blue to enroll South Carolina Medicaid beneficiaries as members in their MCO and to provide the necessary and contractually required health care

services to those members. A summary of the Readiness Review results follows. Details can be found in the narrative section of this report.

Administration

No issues were noted in the processes for developing, managing, and reviewing policies; however, an error was noted in documentation of the committee responsible for policy approval. Staff will be educated about new/revised policies. All key positions are filled, and staffing projections appear to be adequate.

The Compliance Plan described activities to ensure compliance with laws, regulations, and contractual requirements. The Antifraud Plan addressed identifying, detecting, and preventing FWA. Related policies and procedures provided additional information. The Compliance Officer will chair the Compliance Committee and oversee compliance activities. A written Compliance Plan and code of conduct describe expectations for compliance with laws, regulations, contractual requirements, and business conduct. All staff must complete compliance training at employment and annually.

A Pharmacy Lock-in Program is in place to manage members with inappropriate use of pharmacy benefits. The timeframe for notifying members of their inclusion in the program was not found in policy.

Information systems and related policies and procedures meet requirements. Healthy Blue follows best practices for monitoring and responding to security issues and conducts audits of system controls performance. Processes for ensuring member privacy and confidentiality are in place.

Member Services

Healthy Blue addresses member rights and responsibilities in the Member Handbook, Provider Manual, and policies. Onsite discussion indicated information about rights and responsibilities will be made available on the Healthy Blue website and in the initial enrollment member kit. Healthy Blue's Onboarding letter provides contact information and hours of operation for the customer service call center.

The Member Handbook defines routine and emergent services, covered benefits, specialty services, resources, and important phone numbers such as Customer Services, Member Services, and the 24-Hour Nurse Line. Printed materials and verbal assistance are available to members in languages other than English as needed.

Processes for grievance filing and handling are described in the Member Handbook, Provider Manual, and policy. Issues were identified regarding the timeframes for grievance acknowledgement and the requirement for notifying a member of their right to file a grievance if the member disagrees with Healthy Blue's request to extend the grievance resolution timeframe.

Quality Improvement

Healthy Blue has developed a QI Program with an overall goal to improve the quality and safety of clinical care and services provided to members. The 2024 Healthy Blue Medicaid Quality Management and Improvement Program Description includes the program's structure and staffing resources; however, staffing only included the senior level staff resources. There were several positions not mentioned. Also, the program's methodology or the QI model Healthy Blue will use appeared to be incomplete.

Annually, Healthy Blue will develop a QI work plan that will include specific activities and objectives, the responsible staff, and specific timeframes for completion of each activity. The Clinical Quality Improvement Committee has been established as the committee responsible for providing oversight and direction of the QI Program. At least annually, Healthy Blue will formally conduct an evaluation of the QI Program.

For the PM and PIP validation, Constellation Quality Health reviewed Healthy Blue's plan for collecting and reporting HEDIS measures and determining and documenting projects. There were two policies submitted related to specific aspects of HEDIS measures. The overall HEDIS calculation-based policies and procedures were not included. The policies should outline a broader overview of the HEDIS procedures that will be used, including documentation.

The PIP policy did not indicate that other performance data based on priority topics, utilization data, or other system data may be included as part of the project. Healthy Blue provided a project template to be used for documenting the PIPs, but this template did not include all the elements that are required by the CMS protocol.

Utilization Management

Healthy Blue's Medicaid Integrated Care Management Plan, Pharmacy Program Description, and various policies outline Healthy Blue's Utilization Management (UM) scope and objectives for physical health, behavioral health, and pharmacy services. Healthy Blue's Chief Medical Director provides oversight of the UM Program and the Behavioral Health Medical Director and Chief Pharmacy Officer provide clinical oversight of their respective programs. UM reviewers who make initial clinical determinations are licensed practitioners within their respective healthcare disciplines.

Healthy Blue's Integrated Care Management Plan describes various referral sources that aid in identifying potential members for case management services, and care management activities are conducted to address the members' identified needs.

Appeal submission and review processes are outlined in the Provider Manual, Member Handbook, Staff Utilization Review Manual, Program Descriptions, and various policies. Constellation Quality

Health identified issues with the definition of an appeal, the procedures for filing an appeal, timeliness for notification and resolution of an appeal, and the continuation of benefits.

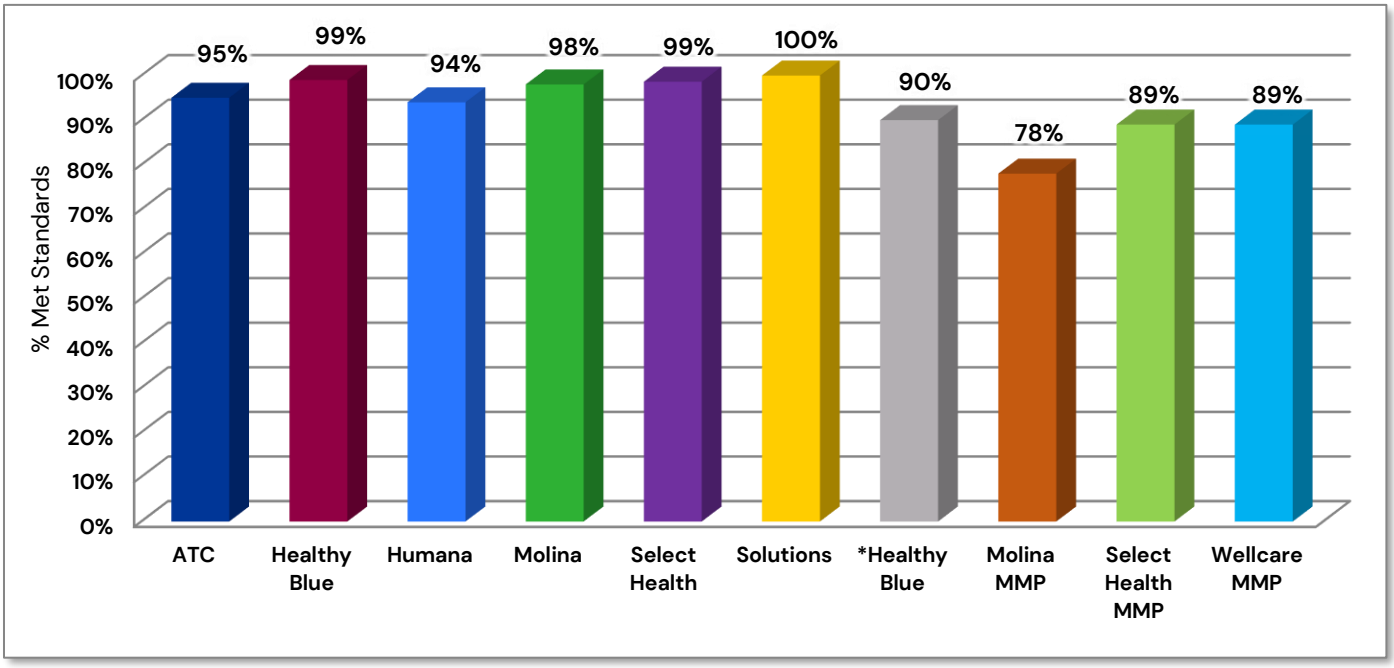
Delegation

Pre-delegation assessments are conducted to determine potential delegates' abilities to perform the delegated functions or services in compliance with all requirements. Healthy Blue submitted documentation of pre-delegation assessments for three entities. All were found to be compliant with requirements. Annual audits are conducted for each approved delegate. Healthy Blue submitted copies of the annual audits conducted for nine credentialing delegates. The annual audits were conducted in a timely manner and identified issues were documented. Outside of the annual audits, regular oversight and monitoring is conducted for all delegates through review of routine reporting. Reports are presented to the Compliance Committee, and corrective action plans are issued to resolve delegate compliance or performance issues.

Conclusions

Overall, the health plans met most of the standards reviewed during the 2023 – 2024 EQRs. The following figure illustrates the percentage of "Met" standards achieved by each health plan. Also, *Table 3: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of the health plans compliance scores specific to each of the *Subpart D* and QAPI standards where applicable.

Figure 1: Health Plans Overall Percentage of Met Standards



Scores were rounded to the nearest whole number
**Readiness Review*

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

Federal Standards	ATC	Healthy Blue	Humana	Molina	Select Health	SC Solutions	Healthy Blue (Readiness)
Disenrollment Requirements and Limitations *(§ 438.56)*	100%	100%	100%	100%	100%	N/A	100%
Enrollee Rights Requirements *(§ 438.100)*	50%	100%	100%	100%	100%	N/A	100%
Emergency and Post-Stabilization Services *(§ 438.114)*	100%	100%	100%	100%	100%	N/A	100%
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	75%	88%	92%	88%	92%	N/A	N/A
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	100%	100%	100%	89%	100%	100%	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	92%	100%	100%	93%	93%	N/A	100%
Provider Selection *(§ 438.214, § 457.1233)*	98%	97%	98%	100%	100%	N/A	N/A
Confidentiality *(§ 438.224)*	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	100%	95%	85%	95%	95%	N/A	66.6%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	50%	100%	50%	100%	100%	N/A	53.8%
Practice Guidelines *(§ 438.236, § 457.1233)*	100%	100%	100%	100%	100%	N/A	N/A
Health Information Systems *(§ 438.242, § 457.1233)*	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	100%	100%	75%	100%	100%	100%	53.8%

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

Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation Quality Health requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. Technical assistance is provided to each health plan until all deficiencies are corrected. During the current

EQR, Constellation Quality Health assessed the degree to which each health plan implemented the actions to address deficiencies identified during the previous EQR. Findings of the EQRs confirmed Healthy Blue, SC Solutions, and Select Health corrected all issues identified during the previous EQR. ATC, Humana, Molina, and the CICOs were found to have uncorrected deficiencies as noted in *Table 4: Uncorrected Deficiencies from Previous EQR*. The complete QIP report for each health plan is attached to this report.

Table 4: Uncorrected Deficiencies from Previous EQR

Health Plan	Uncorrected Deficiencies
ATC	The annual delegation oversight documentation was not submitted for Envolve People Care Behavioral Health. Also, the Credentialing Committee minutes did not reflect the review and discussions of the credentialing delegation oversight.
Humana	For the second consecutive year, the Member Services Manager position is out of compliance with contractual requirements.
	The Quality Assurance Committee lacks a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*.
	The errors regarding missing data or results and incorrect goals being measured were not corrected in the QI Program Evaluation provided for this EQR.
Molina	Molina was still requiring a written appeal request when a verbal request is received even though this requirement was removed from the *SCDHHS Contract* and the Federal Regulations.
Molina MMP	A review of a sample of TOC files revealed the following: • Some calls were documented to check on the member's inpatient status, but very few instances of collaboration with facility Case Management or Discharge Planning staff to ensure safe transition were documented. • Primary care provider (PCP) notifications of admission and discharge were inconsistent. • Documentation of identified needed clinical and non-clinical supports, transition/aftercare appointments, and barriers to after-care was lacking in most files. • Some files had no documented attempts to contact the member to conduct the 72-hour follow-up post discharge. However, some files did include documented attempts to conduct the 72-hour follow-up, but many of the first attempts were outside of the 72-hour window. • Few files included documentation of post-discharge assessments.
Select Health MMP	There were issues noted in the reviewed files, including: • Some files reflected no attempts to contact the facility's Case Management/Discharge Planning staff to collaborate in discharge planning. • Some files did not provide evidence of any collaboration with the PCP when the member was admitted or discharged. • Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done.
Wellcare MMP	Issues noted in the care transitions files included: • Untimely attempts to contact members/caregivers within 72-hours of discharge for eight member files. • Lack of documentation of interaction with facility Case Managers or Discharge Planners was noted for six files. • Lack of documentation of collaboration with the PCP was noted for three files.

Assessment and Recommendation for SCDHHS' Quality Strategy

Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under *§438.340*, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.

SCDHHS' requirement that MCOs must achieve NCQA accreditation and its stipulations regarding the number of PIPs that plans must conduct indicate that the State is committed to a higher level of quality monitoring and accountability for its health plans. The Quality Strategy draft for May 2022 outlined several SCDHHS goals and objectives that align with CMS priority areas. Based on the goals in the Quality Strategy, Constellation Quality Health developed recommendations to allow MCOs to fulfill the objective of the Quality Strategy. The results of 2023-2024 EQR activities demonstrate that the managed care organizations are well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for SC members. *Table 5: SCDHHS Quality Initiatives* displays the recommendations for each initiative.

Table 5: SCDHHS Quality Initiatives

SCDHHS Quality Goal	Recommendation
Ensure the quality and appropriateness of care delivered to members enrolled in managed care	Implement Comprehensive Quality Assurance Programs • Develop and implement robust quality assurance programs that encompass regular audits, clinical reviews, and feedback mechanisms to continuously monitor the quality and appropriateness of care. • Utilize evidence-based guidelines and best practices to guide clinical decision-making and ensure that care delivered aligns with established standards. • Foster a culture of continuous QI within MCOs by providing training and resources to healthcare providers and staff, encouraging peer review, and promoting transparency in reporting outcomes. Enhance Care Coordination and Continuity • Strengthen care coordination efforts by promoting communication and collaboration among healthcare providers, including PCPs and specialists. • Implement mechanisms for seamless transitions of care between different settings, such as hospitals, primary care clinics, and long-term care facilities, to ensure continuity and prevent gaps in care. • Facilitate the use of health information exchange systems to enable real-time sharing of patient information and facilitate coordinated care planning across providers and care settings. Promote Patient Engagement and Empowerment • Empower Medicaid members to actively participate in their care decisions by providing education, resources, and support to enhance health literacy and self-management skills. • Offer culturally and linguistically appropriate services to ensure that members can fully understand their health conditions, treatment options, and rights within the managed care system. • Solicit feedback from members through surveys, focus groups, and advisory committees to assess satisfaction levels, identify areas for improvement, and

SCDHHS Quality Goal	Recommendation
	incorporate patient preferences into care delivery processes.
Assure Medicaid Members have access to care and a quality experience of care	Implement Comprehensive Quality Assurance Programs • Develop and implement robust quality assurance programs that encompass regular audits, clinical reviews, and feedback mechanisms to continuously monitor the quality and appropriateness of care. • Utilize evidence-based guidelines and best practices to guide clinical decision-making and ensure that care delivered aligns with established standards. • Foster a culture of continuous QI within MCOs by providing training and resources to healthcare providers and staff, encouraging peer review, and promoting transparency in reporting outcomes. Enhance Care Coordination and Continuity • Strengthen care coordination efforts by promoting communication and collaboration among healthcare providers, including PCPs, specialists, and ancillary service providers. • Implement mechanisms for seamless transitions of care between different settings, such as hospitals, primary care clinics, and long-term care facilities, to ensure continuity and prevent gaps in care. • Facilitate the use of health information exchange systems to enable real-time sharing of patient information and facilitate coordinated care planning across providers and care settings. Promote Patient Engagement and Empowerment • Empower Medicaid members to actively participate in their care decisions by providing education, resources, and support to enhance health literacy and self-management skills. • Offer culturally and linguistically appropriate services to ensure that members can fully understand their health conditions, treatment options, and rights within the managed care system. • Solicit feedback from members through surveys, focus groups, and advisory committees to assess satisfaction levels, identify areas for improvement, and incorporate patient preferences into care delivery processes.
Ensure MCO Contract Compliance	Establish Clear Performance Standards and Metrics • Define clear performance standards and metrics within MCO contracts, aligning them with state and federal regulations, accreditation requirements, and QI goals. • Implement regular monitoring and reporting mechanisms to track MCO performance against contractual obligations, including adherence to clinical guidelines, provider network adequacy, and member satisfaction benchmarks. • Conduct periodic audits and reviews to assess MCO compliance with contract terms and identify areas for improvement or corrective action. Enhance Transparency and Accountability • Foster transparency in MCO operations by providing stakeholders, including Medicaid members, policymakers, and advocacy groups, with access to relevant performance data, quality reports, and audit findings. • Establish mechanisms for stakeholder engagement and feedback, such as advisory committees or public forums, to ensure that the perspectives and concerns of various stakeholders are considered in MCO oversight and decision-making processes. • Hold MCOs accountable for meeting contractual obligations through performance-based incentives, financial penalties for non-compliance, or

SCDHHS Quality Goal	Recommendation
	other accountability mechanisms outlined in the contract. Provide Technical Assistance and Support • Collaborate with MCOs to identify barriers to compliance and develop tailored strategies and resources to address them, such as staff training programs, workflow enhancements, or technology upgrades. • Facilitate peer learning and knowledge sharing among MCOs by organizing workshops, webinars, or networking events focused on best practices in contract management, QI, and regulatory compliance.
Manage Continuous Performance Improvement	Data-Driven Decision Making • Utilize advanced analytics and data mining techniques to identify trends, patterns, and areas of opportunity for improvement in both clinical and nonclinical areas. • Maintain and revise key performance indicators (KPIs) aligned with organizational goals and regularly monitor progress against these metrics to track performance and identify areas needing intervention. • Foster a culture of data transparency and accountability, where stakeholders at all levels have access to relevant performance data and are empowered to use it for decision-making and QI efforts. Promote Interdisciplinary Collaboration • Encourage collaboration among multidisciplinary teams comprising healthcare providers, administrators, quality improvement specialists, and community partners to drive performance improvement initiatives. • Facilitate regular meetings or huddles to review performance data, share best practices, and brainstorm innovative solutions to common challenges or barriers. • Establish cross-functional improvement teams tasked with addressing specific quality improvement priorities identified through data analysis or stakeholder input, ensuring diverse perspectives and expertise are leveraged. Sustain Improvement Efforts Through Continuous Monitoring • Develop mechanisms for ongoing monitoring and evaluation of improvement initiatives to ensure sustainability of gains over time. • Implement systems for tracking and reporting on the progress of performance improvement projects, celebrating successes, and identifying opportunities for further refinement or scale-up.
Conduct Targeted Population Quality Activities	Address Healthy Equality and Inclusivity • Conduct comprehensive needs assessments and data analysis to identify high-priority subpopulations within the Medicaid beneficiary population, such as pregnant women, children with special healthcare needs, or individuals with chronic conditions. • Develop targeted quality improvement initiatives and interventions tailored to address the unique needs, preferences, and risk factors of each identified subpopulation. • Collaborate with community-based organizations, advocacy groups, and social service agencies to leverage resources and expertise in designing and implementing culturally sensitive and linguistically appropriate interventions. Integrate Behavioral Health and Social Determinants of Health (SDOH) into Quality Improvement Efforts • Recognize the importance of addressing behavioral health issues and SDOH in improving overall health outcomes for Medicaid beneficiaries. • Embed screening, assessment, and referral processes for behavioral health

SCDHHS Quality Goal	Recommendation
	conditions and SDOH factors into routine care delivery workflows within MCOs and provider networks. • Implement evidence-based interventions and care coordination strategies to address identified behavioral health needs and social determinants, such as housing instability, food insecurity, or substance use disorders. Leverage Performance Incentives and Withhold Metrics • Use performance incentives and withhold metrics as levers to drive targeted population QI activities within Medicaid managed care contracts. • Establish clear performance benchmarks and milestones for targeted population QI initiatives, regularly monitoring progress and adjusting strategies as needed to ensure desired outcomes are achieved.

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

Recommendations and Opportunities for Improvements

The following is a summary of strengths, weaknesses, and recommendations or opportunities for improvement for the MCOs. Specific details of strengths, weaknesses, and recommendations for Solutions, Healthy Blue's readiness review, and the CICOs can be found in the sections that follow.

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

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for development, review, and ongoing management of policies and procedures.	✓		
No staffing issues were noted for ATC, Healthy Blue, Molina, and Select Health.	✓		
Organizational Charts display reporting and operational relationships, key positions, temporary/contingent personnel, shared services staff, vacant positions, etc.	✓		
All the MCOs meet or exceed the claims processing timeliness requirements defined in the SCDHHS Contract.	✓	✓	
The plans have appropriate systems and processes in place to maintain system security and to prevent unauthorized data access.	✓		
Detailed disaster recovery and/or business continuity plans are in place.	✓		
Compliance Plans, FWA Plans, codes of conduct, and related policies and procedures provide guidance about expectations for compliance with laws, regulations, and contractual requirements; preventing, detecting, and responding to FWA; and expectations for appropriate business conduct.	✓		
Compliance Committees are in place to assist in the implementation and oversight of the Compliance Programs. Humana is establishing a health plan level Compliance Committee.	✓		
Employees are required to complete initial and annual compliance training.	✓		
Each health plan has a Pharmacy Lock-In Program to manage inappropriate use of pharmacy benefits.	✓		✓

Strengths	Quality	Timeliness	Access to Care
Processes for ensuring confidentiality are included in compliance training, policies, codes of conduct, etc.	✓		
Provider Services			
Each health plan has a committee to make credentialing and recredentialing decisions for providers that cannot be approved by the Medical Director/Chief Medical Officer.	✓		✓
Credentialing Committees meet routinely and use a peer-review process to make credentialing decisions. A quorum is established prior to making decisions or taking other actions.	✓		
No issues were identified in initial credentialing and recredentialing files for organizational providers.	✓		
Appropriate processes are in place to conduct monthly monitoring to ensure providers are not prohibited from receiving Federal funds.	✓		✓
Four of the five MCOs appropriately document PCP geographic access standards and appointment access standards in policies.			✓
The health plans conduct various activities to formally assess and conduct ongoing monitoring of network adequacy and address any identified network gaps.			✓
The MCOs ensure their network providers can meet the cultural, diversity, and language needs of members.			✓
Successful contact rates for provider call studies conducted by Constellation Quality Health improved for four of five MCOs.			✓
Appropriate processes are in place for initial provider orientation and ongoing provider education.	✓		✓
The MCOs adopt, educate providers about, and assess provider compliance with clinical practice and preventive health guidelines.	✓		✓
The MCOs monitor continuity and coordination of care between PCPs and other providers through medical record reviews and monitoring HEDIS and CAHPS survey results.	✓		✓
The health plans educate providers about medical record documentation standards and assess provider compliance through routine medical record audits. Action is taken to address identified issues.	✓		
Member Services			
Members are informed of their rights and responsibilities through Member Handbooks, newsletters, and health plan websites.	✓		
The Member Handbook is a comprehensive resource for members to understand their benefits and health plan services and processes.			✓
Each health plan ensures member materials are understandable and available in alternate formats as needed to meet member needs.			✓
Member satisfaction results are examined internally.	✓		
Various communication strategies are used to provide information about programs and services and to encourage members to get recommended preventive services. These include welcome packets, telephonic outreach, email, automated text messages and calls, newsletters, etc.			✓
For the 2023 EQR, the sample of grievance files reviewed for three health plans reflected timely resolution.		✓	
Quality Improvement			
The QI Programs developed by the MCOs focus on the health care and services their members receive and include all aspects of health care quality.	✓		

Strengths	Quality	Timeliness	Access to Care
The MCOs have developed QI work plans that include the QI activities and objectives, timeframes for expected completion, responsible parties, and any ongoing monitoring notes.	✓		
Topics for the PIPs were selected from problems and/or needs pertinent to the member population.	✓		
The study design for QI projects met the requirements of the CMS protocol	✓		
Utilization Management			
Approval files were completed in a timely manner and reviewers utilized appropriate clinical criteria guidelines.		✓	✓
Denial decisions were made by an appropriate physician and the reasons for the denials were clearly documented.	✓		✓
ATC and Humana exceed the targeted monthly goal in processing service authorization requests.		✓	✓
Healthy Blue, ATC, and Humana have developed specialized programs and initiatives to increase member engagement in the care management program.			✓
All five MCOs have outlined policies and guidelines for analyzing trends and patterns for over- and underutilization.	✓		
The MCOs engage in patient education and outreach efforts to empower Medicaid beneficiaries to make informed healthcare decisions, seek appropriate care when needed, and avoid unnecessary utilization of services.	✓		✓
A review of the desk materials demonstrated collaboration and coordination among healthcare providers, managed care organizations, and other stakeholders to share data, best practices, and strategies for monitoring and addressing over- and underutilization effectively.	✓		
Of the appeal files reviewed for each MCO, all were addressed timely and were reviewed by appropriately credentialed personnel.		✓	✓
Delegation			
Processes for pre-delegation assessments, approval of delegation, annual delegation oversight, and ongoing monitoring are thoroughly documented in policies.	✓		
No issues were identified for Healthy Blue, Molina, and Select Health when reviewing the delegate oversight documentation provided by each of the MCOs.	✓		
Mental Health Parity			
The Mental Health Parity assessments 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.			✓
UM criteria and processes achieve parity.			✓
Inter-Rater Reliability incorporates both mental health and substance use disorder and medical/surgical cases.	✓		

Table 7: Weaknesses and Recommendations Related to the Quality, Timeliness, and Access to Care

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Administration				
For the second consecutive year, Humana was not in compliance with contractual requirements for the position of Member Services Manager.	Ensure compliance for all key positions required by the *SCDHHS Contract*.	✓		
For ATC and Humana, issues were identified with documentation of processes for conducting exclusion status monitoring for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO.	Ensure compliance with contractual requirements for exclusion status monitoring for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO	✓		
Provider Services				
ATC and Healthy Blue policies do not address all required credentialing elements. Humana's policy incompletely addressed appeals of credentialing determinations.	Ensure credentialing processes and requirements are fully documented in applicable policies and procedures.	✓		
Three of the five health plans were noted to have limited external providers on their Credentialing Committees.	Continue efforts to recruit additional external providers, particularly specialty providers, for membership of health plan Credentialing Committees.	✓		
Review of credentialing and recredentialing files revealed issues related to verification of admitting privileges (Humana, Molina, Select Health), verification of CLIA (Humana), and collection of nurse practitioner collaborative agreements (Humana).	Ensure credentialing and recredentialing files include all required elements.	✓		✓
For ATC, documentation of the geographic access standards for primary care and specialty providers was not located in any policy.	Ensure geographic access standards for primary care and specialty providers are thoroughly documented in policy.			✓
Healthy Blue's Network Analyses for Driving Time and Driving Distance report did not include all required Status 1 provider types.	Ensure Geo Access mapping includes all required Status 1 provider types, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2*.			✓
For Molina, multiple issues were noted with documentation of specialty care appointments in policy, the Provider Manual, and Member Handbook.	Ensure specialty appointment access standards are thoroughly and correctly documented in policies, Provider Manuals, and Member Handbooks.			✓
Two of the five MCOs did not include contractually required information in their online "find a provider" search tools.	Ensure all contractually required information is posted in online "find a provider" search tools.			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Appointment availability for routine appointments was below 85% for all five health plans.	Educate providers on requirements for appointment availability during touchpoints.			✓
The percentage of providers accepting new Medicaid patients was at or below 85% for all five health plans.	Determine ways to increase panels for providers; increase providers at locations to ensure new members can be added to provider panels.			✓
Member Services				
ATC's policy did not include all member rights.	Include all member rights and responsibilities outlined in the *SCDHHS Contract* in policy.	✓		✓
Discrepancies were noted in Humana's policies, Member Handbook, and Provider Manual regarding the timeframe for grievance acknowledgement.	Verify the timeframe for acknowledging a grievance and include the correct timeframe in all materials.		✓	
Humana's grievance acknowledgement letters did not indicate that a grievance may be filed if the member disagrees with the health plan's request for an extension.	Include the notification that a member may file a grievance if they disagree with the health plan's request for an extension in the acknowledgement letter.	✓		
Some of Humana's grievance files were closed with significant time remaining and members were instructed to contact the health plan to provide further information.	Establish processes or training to ensure that grievances are not closed with significant time remaining when additional information is needed.		✓	
Quality Management				
Healthy Blue's website contained information regarding the QI Program; however, this information was from 2021 and therefore, outdated.	Ensure the QI information shared with members and providers is current.	✓		
Two of the MCOs' QI work plans contained errors and/or missing information.	Errors and missing information should be corrected in the QI work plans.	✓		
Humana's QI Committee lacked a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*. This continues to be an issue for Humana.	To ensure Humana is compliant with the *SCDHHS Contract*, additional participating network providers should be recruited to serve on the QI Committee.	✓		
Humana's QI Committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings. No documentation was noted when minutes were changed or amended.	For voting members absent during the committee meeting, the minutes should reflect the appointed representative. A process for how errors or changes in the committee minutes should be documented and reported to the committee.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation was missing data or results and contained goals that were incorrect. There were issues identified during the previous EQR and not corrected.	To assess the effectiveness of the QI Program, the results of all activities must be analyzed, barriers identified, and recommendations included in the annual QI Program Evaluation.	✓		
For the Immunizations for Adolescents PIP conducted by Molina, there was a slight decline in the administrative rate to 28.35%.	Additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.	✓		✓
For the Well Care PIP conducted by Molina, the rate showed a slight decline in the HEDIS well child visit rate from 44.11% at baseline to 43.36%.	Continue to assess interventions to determine the impact on the final measure rate that will be available in mid-2023.	✓		
For the Diabetes Outcomes PIP conducted by Select Health, the results showed a slight decline in the hemoglobin A1C measure and the blood pressure control measure.	Continue to assess interventions and consider sub-analysis to determine if specific subsets of the population are impacting the reduction in rates.	✓		
The Well Care Visits for Foster Care Population PIP conducted by Select Health showed a decline in the Adolescent well care rate, the well child visit in the first 15 months, the well child visits in third, fourth, fifth, and sixth years of life, the well child visits in the first 30 months of life, the well child visit for 3-11 years, the well child visit for 12-17 years, and the total well child visit rate.	Continue interventions and assess impact of each intervention wherein possible.	✓		
Utilization Management				
There was no information regarding when the negative PDL changes were published on Select Health's website.	Ensure notices of negative PDL changes are posted on the health plan's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*		✓	✓
Molina's procedure incorrectly referenced the criteria utilized by reviewers when making clinical coverage determinations.	Policies, procedures, and program descriptions should reference the criteria utilized by reviewers when making clinical coverage determinations.	✓		✓
ATC had inconsistent information in the UM Program Description and policy regarding the timeframe for providers to notify ATC of a service authorization request.	Correct the inconsistencies in program materials regarding timeframes for services authorization requests and pharmacy authorizations.		✓	✓
The Preferred Provider Programs for two health plans lacked details regarding the process for inclusion in	Develop and implement a Preferred Provider Program in accordance with *SCDHHS Contract,*	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
the program, tracking the provider status, and the process for making providers aware of the program.	*Section 8.5.2.8* and include the specifics for the program in respective policies.			
Member notices (Humana, ATC, and Molina) and a UM Program Description (Molina) incorrectly indicate that a written appeal is required when an oral appeal request is submitted. This issue was identified during the previous EQR for Molina and not corrected.	Remove the requirement that a written appeal must be submitted following an oral request for appeal in member notices and UM Program Descriptions.			✓
The care management files for Molina did not include the date the Individualized Care Plan was developed and did not have documentation of a follow-up schedule for members receiving case management services.	Improve the documentation in the care management files to include the date the Individualized Care Plan was developed and documentation of follow-up to assess member progress.	✓	✓	
Humana's policy and appeal acknowledgement letter did not address the requirement that members may file a grievance if they disagree with an extension of the appeal resolution timeframe.	Notify members that a grievance may be filed if they disagree with the health plan's request to extend the appeal resolution timeframe.			✓
Healthy Blue and Select Health's appeal files had issues with the appeal acknowledgements and the resolution timeframe.	Ensure that acknowledgement letters are sent when a member requests an appeal and the letter includes the correct timeframe for resolutions.		✓	✓
Delegation				
The review of delegate oversight documentation provided by each of the MCOs revealed issues related to: • Noncompliance with health plan policy to report credentialing delegation oversight summaries to the Credentialing Committee (ATC). This was an uncorrected deficiency from the previous EQR. • Failure to include in applicable policy the requirement to notify SCDHHS of any further delegation by a subcontractor (Humana). • Incorrect indications of "not applicable" on credentialing delegation oversight audit tools for required credentialing elements (Humana). • Failure to consistently monitor credentialing delegates for checking	Ensure delegation oversight activities incorporate all contractual and policy requirements, and that delegation oversight reporting is consistent with policy requirements	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
hospital admitting privileges during file review (Humana).				
Mental Health Parity Assessment				
ATC provided insufficient documentation to conduct the assessment of Mental Health Parity.	To determine compliance with the Mental Health Parity and Addiction Equity Act, ATC must complete the Mental Health Parity templates and reports and submit these documents to Constellation Quality Health for review.	✓		
Humana's provider Network is not robust in certain regions, reflected in low scores for getting mental health services quickly on the ECHO survey.	Continue to convene the Network Adequacy Workgroup. Continue the policy of not denying care based on the provider's contracted status.			✓
Integration issues with FOCUS, Humana's Behavioral Health vendor who performs reviews when associates are unable to approve a request, could result in timeliness or access to care issues.	Continue with training and staff support as well as JOC meetings.			✓
Select Health's 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 medical/surgical. 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.	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.			✓

BACKGROUND

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

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

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

Constellation Quality Health is required by contract to validate the MCO's consumer and provider surveys, conduct quality of care studies, and readiness reviews.

After completing the review of the required and optional EQR activities, Constellation Quality Health submits a detailed technical report to SCDHHS and the health plan. This report describes the data aggregation and analysis and manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths, weaknesses, recommendations for improvement, and the degree to which the plans addressed quality improvement recommendations made during the prior year's review.

Annually, Constellation Quality Health prepares a comprehensive technical report for the State which is a compilation of the individual annual review findings. For 2023-2024, this report contains data for ATC, Healthy Blue, Humana, Molina, and Select Health and also includes EQR findings for the plans participating in the Healthy Connections Prime Program under review during this reporting period. Those included: Select Health, Molina, Wellcare.

METHODOLOGY

The process Constellation Quality Health used for the EQR activities was based on protocols CMS developed for the EQR of a Medicaid MCO and includes a desk review of documents submitted by each health plan and virtual onsite visits. After completing the annual review, Constellation Quality Health submits a detailed technical report to SCDHHS and the health plans. For a health plan not meeting requirements, Constellation Quality Health requires the plan to submit a quality improvement plan for each standard identified as not fully met. Technical assistance is provided to each health plan until all deficiencies are corrected. A copy of the QIP reports is included as an

attachment to this report. The following table displays the dates of the EQRs conducted for this contract period.

Table 8: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Report Submitted
ATC Wellcare MMP	10/16/23	12/6/23 – 12/7/23	1/4/24
Healthy Blue	3/13/23	6/21/23 – 6/22/23	7/20/23
Humana	12/4/23	2/7/24 – 2/8/24	3/7/24
Molina Molina MMP	2/13/23	5/17/23 – 5/18/23	6/16/23
Select Health Select Health MMP	8/4/23	9/20/23 – 9/21/23	10/20/23
Solutions	6/12/23	8/23/23	9/14/23
Healthy Blue (Readiness Review)	7/18/23	10/10/23	11/8/23

FINDINGS

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

A. Administration

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

The Administration section of the EQR focuses on policy management, MCO staffing, information management systems, compliance, program integrity, and confidentiality.

Each of the health plans follows appropriate processes for policy and procedure development, management, and ongoing review. The health plans review and revise policies annually, educate staff about new and revised policies, and house policies in locations that are accessible by staff.

The MCOs' Organizational Charts display reporting and operational relationships of staff and indicate key positions, temporary/contingent personnel, shared services staff, vacant positions, etc. Review of the Organizational Charts and the related onsite discussion confirmed four of the five plans were compliant with requirements for key personnel; however, Humana was not in compliance with contractual requirements for the position of Member Services Manager for the second consecutive year. During the previous EQR, one SC staff was serving in both the Member Services Manager and Contract Account Manager positions. For the 2024 EQR, the Member Services Manager position is filled on an interim basis by a Humana Associate Vice President, Inbound Contacts, who is located in MN. The *SCDHHS Contract, Section 2*, requires that the MCO have one full-time, in-state employee to serve as Member Services Manager.

The MCOs' Compliance Plans documented processes for ensuring compliance with applicable laws, regulations, contractual requirements, and accreditation standards. Fraud, Waste and Abuse (FWA) Plans described processes for preventing, detecting, and responding to alleged or actual FWA. Related policies and procedures provide additional detailed documentation about compliance and FWA. Health plan codes of conduct provide guidance to staff about appropriate and ethical business behavior.

The Compliance Plans and related policies address the roles and responsibilities of the Compliance Officers and Compliance Committees and include information about compliance training; communication; enforcement, monitoring, and auditing activities; and data mining, analysis, and reporting activities. For ATC and Humana, issues were identified with processes for conducting exclusion status monitoring for subcontractors and persons with ownership or control interest or who are agents or managing employees of the MCO.

Compliance Committees are in place to assist in the implementation and oversight of the MCOs' Compliance Programs. The committees meet at routine intervals and require the presence of a quorum to make decisions. For Humana, the Corporate Compliance Committee is the decision-making authority for compliance matters, and issues that affect SC are discussed during Medicaid Compliance Steering Committee meetings. The Medicaid Compliance Steering Committee membership includes business and compliance leaders throughout Humana that support the SC Medicaid program, including the South Carolina Medicaid Compliance Officer. Humana reported that a health plan level Compliance Committee is being established and is expected to hold its first meeting by the end of Q1 2024.

The MCOs have established Pharmacy Lock-In Programs to manage inappropriate use of pharmacy benefits. No issues were noted with the Pharmacy Lock-in Programs for ATC, Healthy Blue, Molina, and Select Health. Humana's South Carolina Medicaid Pharmacy Lock-In Program policy (SC.RX.004) did not clearly document the process followed when members appeal the decision to include them in the program, did not include the 72-hour limitation on an emergency supply of medication, and did not address the process for notifying members when they are removed from the program.

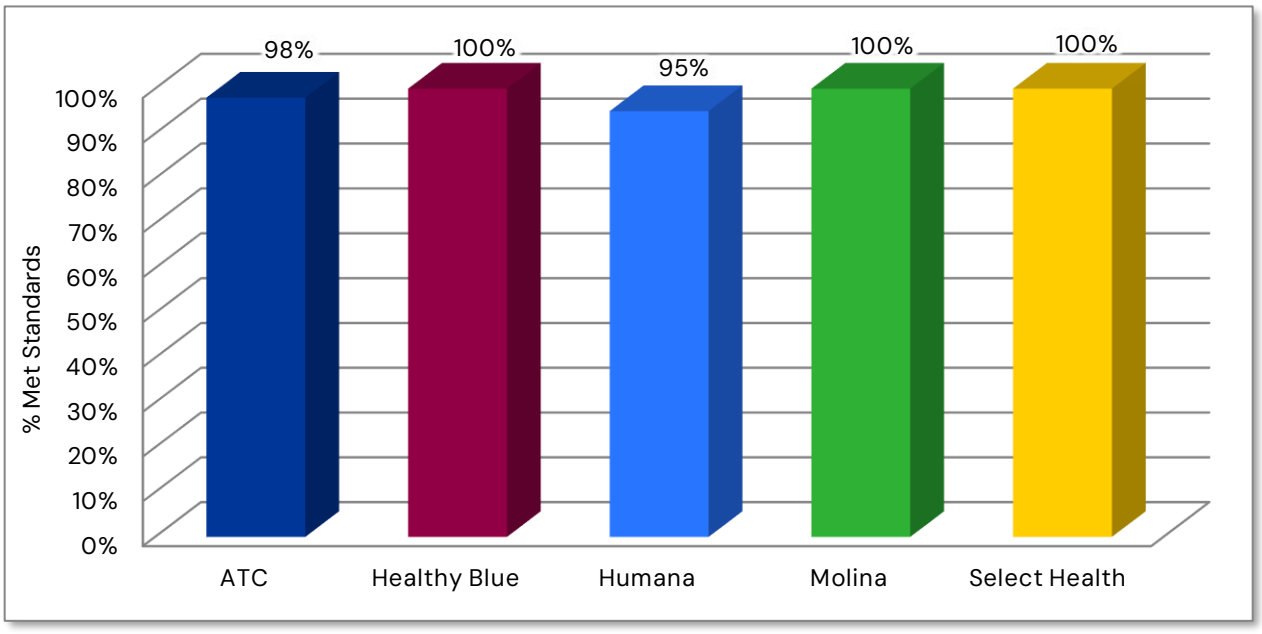
The health plans expect employees, providers, and subcontractors to maintain confidentiality of protected information. Processes for ensuring confidentiality are included in compliance training, policies, codes of conduct, etc.

Information Management Systems Assessment

All the MCOs meet or exceed the claims processing timeliness requirements defined in the *SCDHHS Contract*. The plans can accept and generate HIPAA-compliant transactions, and documentation reflects the use of Electronic Data Interchange systems that meet security requirements. The health plans track member enrollment and demographic information, track members across product lines, and monitor for and take action to resolve duplication of member records. No issues were identified with the plans' information management system capabilities to support required reporting to the State. Processes for ensuring the security of data are in place and are documented in policies and procedures. Risk assessments are conducted to ensure the integrity of these processes. ATC, Healthy Blue, Molina, and Select Health have disaster recovery plans to ensure system and data integrity, availability, and confidentiality. In addition, Healthy Blue and Molina have detailed business continuity plans.

As noted in *Figure 2: Administration Findings*, the percentage of "Met" scores for the Administration section ranged from 95% to 100%.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, and recommendations are detailed in *Table 9: Administration Strengths* and *Table 10: Administration Weaknesses and Recommendations*.

Table 9: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for development, review, and ongoing management of policies and procedures.	✓		
No staffing issues were noted for ATC, Healthy Blue, Molina, and Select Health.	✓		
Organizational Charts display reporting and operational relationships, key positions, temporary/contingent personnel, shared services staff, vacant positions, etc.	✓		
All the MCOs meet or exceed the claims processing timeliness requirements defined in the SCDHHS Contract.	✓	✓	
The plans have appropriate systems and processes in place to maintain system security and to prevent unauthorized data access.	✓		
Detailed disaster recovery and/or business continuity plans are in place.	✓		
Compliance Plans, FWA Plans, codes of conduct, and related policies and procedures provide guidance about expectations for compliance with laws, regulations, and contractual requirements; preventing, detecting, and responding to FWA; and expectations for appropriate business conduct.	✓		
Compliance Committees are in place to assist in the implementation and oversight of the Compliance Programs. Humana is establishing a health plan level Compliance Committee.	✓		
Employees are required to complete initial and annual compliance training.	✓		
Each health plan has a Pharmacy Lock-In Program to manage inappropriate use of pharmacy benefits.	✓		✓
Processes for ensuring confidentiality are included in compliance training, policies, codes of conduct, etc.	✓		

Table 10: Administration Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
For the second consecutive year, Humana was not in compliance with contractual requirements for the position of Member Services Manager.	Ensure compliance for all key positions required by the *SCDHHS Contract*.	✓		
For ATC and Humana, issues were identified with documentation of processes for conducting exclusion status monitoring for	Ensure compliance with contractual requirements for exclusion status monitoring for subcontractors and	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO.	persons with ownership or control interest or who are agents or managing employee of the MCO.			

ADMINISTRATION

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
General Approach to Policies and Procedures					
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Met ↑	Met	Met
Organizational Chart / Staffing					
The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED)	Met	Met	Met ↑	Met	Met
Chief Financial Officer (CFO)	Met	Met	Met	Met	Met
*Contract Manager	Met	Met	Met ↑	Met	Met
Information Systems Personnel Claims and Encounter Manager/ Administrator	Met	Met	Met	Met	Met
Network Management Claims and Encounter Processing Staff	Met	Met	Met	Met	Met
Utilization Management (Coordinator, Manager, Director)	Met	Met	Met	Met	Met
Pharmacy Director	Met	Met	Met	Met	Met
Utilization Review Staff	Met	Met	Met	Met	Met
*Case Management Staff	Met	Met	Met	Met	Met
*Quality Improvement (Coordinator, Manager, Director)	Met	Met	Met	Met	Met
Quality Assessment and Performance Improvement Staff	Met	Met	Met	Met	Met
*Provider Services Manager	Met	Met	Met ↑	Met	Met
*Provider Services Staff	Met	Met	Met	Met	Met
*Member Services Manager	Met	Met	Not Met	Met	Met
Member Services Staff	Met	Met	Met	Met	Met
*Medical Director	Met	Met	Met	Met	Met
*Compliance Officer	Met	Met	Met	Met	Met
*Program Integrity Coordinator	Met	Met	Met	Met	Met
Compliance/ Program Integrity Staff	Met	Met	Met	Met	Met
*Program Integrity FWA Investigative/Review Staff	Met	Met	Met	Met	Met
*Interagency Liaison	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Legal Staff	Met	Met	Met	Met	Met
*Behavioral Health Director	Met	Met	Met	Met	Met
Operational relationships of MCO staff are clearly delineated	Met	Met	Met ↑	Met	Met
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*					
The MCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	Met	Met	Met	Met
The MCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met
The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	Met	Met	Met	Met	Met
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	Met	Met	Met	Met	Met
The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented	Met	Met	Met	Met	Met
Compliance/Program Integrity					
The MCO has a Compliance Plan to guard against fraud and abuse	Met	Met	Met	Met	Met
The Compliance Plan and/or policies and procedures address requirements, including: • Standards of conduct • Identification of the Compliance Officer and Program Integrity Coordinator • Inclusion of an organization chart identifying names and titles of all key staff • Information about the Compliance Committee • Compliance training and education • Lines of communication • Enforcement and accessibility • Internal monitoring and auditing • Response to offenses and corrective action • Data mining, analysis, and reporting	Partially Met ↓	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
• Exclusion status monitoring					
The MCO has an established committee responsible for oversight of the Compliance Program	Met	Met	Met	Met	Met
The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met	Met
The MCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met
The MCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met	Met
The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Met	Met	Partially Met ↓	Met	Met
Confidentiality *42 CFR § 438.224*					
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met

B. Provider Services

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

The Provider Services section of the EQRs focuses on provider credentialing, network adequacy, initial and ongoing provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical record documentation.

Provider Credentialing and Selection

Each MCO has developed policies and procedures as well as program descriptions to document the processes and requirements for initial and ongoing credentialing of practitioners and organizational providers. Issues were noted in the documentation of processes for credentialing and recredentialing requirements for organizational providers in policies/procedures. Specifically, these issues were related to:

- The timeframe for processing credentialing applications (ATC).
- Provider appeal rights (Healthy Blue).
- Processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing (Healthy Blue).
- Provider rights and processes for ensuring a non-discriminatory credentialing process (Healthy Blue).
- Processes for verifying that organizational providers have a current Medicaid ID number (Healthy Blue).

Each health plan has a committee responsible for credentialing and recredentialing determinations. The committees meet monthly and are chaired by MCO Medical Directors, Associate Medical Directors, and Chief Medical Officers. Minutes reflected the presence of a quorum for each meeting. The voting membership of each health plan's credentialing committee includes a variety of network practitioners; however, recommendations were offered to Healthy Blue, Humana, and Molina to work toward increasing the variety of specialty providers in the voting membership. Three members of Healthy Blue's committee did not meet the attendance requirements. A recommendation was made to reinforce attendance expectations with voting committee members.

A review of a sample of initial credentialing and recredentialing files for practitioners and organizational providers was conducted for each MCO. No issues were identified in the initial credentialing files for ATC, Healthy Blue, and Molina. For Humana, collection of nurse practitioner collaborative agreements was an identified issue that required a Quality Improvement (QI) Plan. The file review revealed limited issues related to provider

admitting privileges (Humana, Molina, and Select Health), verification of CLIA certification (Humana), and timeliness of verifications conducted (Select Health).

Appropriate processes are in place for suspending or terminating practitioner network participation for serious quality of care or service issues and for ongoing monitoring for potential provider sanctions and exclusions.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Each of the MCOs has policies and procedures for initial provider orientation and education that includes pertinent topics to allow providers to understand health plan processes and requirements. Provider Manuals and health plan websites reinforce the orientation and are comprehensive resources for providers. Healthy Blue's Provider Manual did not address member benefits for BabyNet services or Rehabilitative Services for Children. Each of the MCOs conducts ongoing provider education to update providers about program changes and additions, process changes, member benefits, etc.

Policies define the medical record documentation standards to which providers are expected to comply. Network providers are educated about medical record documentation standards and record-keeping practices through the Provider Manuals, websites, etc. The MCOs assess provider compliance with the documentation and record-keeping requirements through routine medical record audits. For any providers who do not meet the scoring threshold, additional education is provided and a reaudit is conducted.

The MCOs adopt clinical practice and preventive health guidelines that are specific to their memberships' demographics and health care and service needs. These guidelines are evidence-based and adopted from nationally recognized sources to educate providers about recommended preventive services and condition-specific care. The health plans disseminate the guidelines to providers in various ways, including health plan websites, and include information about the guidelines in Provider Manuals, newsletters, faxes, mailings, and provider education sessions. Printed copies are available upon request.

Health plan processes for monitoring continuity and coordination of care are found in policies and/or Program Descriptions. Activities for monitoring continuity and coordination of care include conducting medical record reviews, assessing HEDIS measures, reviewing member and provider satisfaction survey results, etc. The MCOs use results of this monitoring for QI activities and develop interventions to address any identified issues.

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 the MCOs' provider networks following Centers for Medicare and Medicaid Services (CMS) protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plans' provider networks to determine if the MCOs meet network standards defined by the State. To conduct this validation, Constellation Quality Health requested and reviewed the following for each MCO:

- 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.

The MCOs' provider networks were found to be adequate and consistent with the requirements of the CMS protocol, "Validation of Network Adequacy." The following is an overview of the results for each activity conducted to assess network adequacy.

Provider Network File Questionnaire

The purpose of this Provider Network File Questionnaire (PNFQ) is to learn more about each MCO's methods for classifying, storing, and updating provider enrollment data. Constellation reviewed the information submitted by each health plan to determine if adequate procedures and processes are in place to maintain an accurate provider file directory. A summary of the findings is displayed in *Table 11*.

Table 11: Overview of PNFQ Findings

Domain	ATC	Healthy Blue	Humana	Molina	Select Health
Data	Portico	N/A	APEX	N/A	Facets

Domain	ATC	Healthy Blue	Humana	Molina	Select Health
Management System					
Data Verification Procedures	Roster Verification Process	N/A	Provider workflow system	N/A	Executive Validation Process
Updates to Member Directories	Daily	N/A	Daily	N/A	Daily
Geo Access Reporting	Weekly	N/A	Monthly	N/A	Quarterly

Note. N/A: Not applicable due to timing of review

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

The health plans routinely assess the adequacy of their provider networks through Geo Access mapping, network adequacy reports, member grievances related to practitioner access, member satisfaction survey results, etc. Gaps are analyzed and interventions are developed to address the gaps. The health plans document geographic access standards in policies, but ATC's policy listed only the standards for acute care hospitals. Select Health's policy appropriately documented the geographic access standard for primary care providers (PCPs) according to the contractual requirement; however, incorrect parameters were listed in Select Health's Annual Network Development Plan. Healthy Blue's Network Analyses for Driving Time and Driving Distance report did not include all required Status 1 provider types.

Provider appointment access standards are documented in policies. It was found that Molina's policy did not include the requirements for specialty provider emergent visits and urgent medical condition care appointments. Additionally, appointment standards for specialty providers were not clearly documented and/or were incomplete in Molina's Provider Manual and Member Handbook. Constellation Quality Health noted that Select Health's 2022 Network Development Plan incorrectly lists the standard for routine new patient appointments. The MCOs evaluate provider compliance with the appointment access standards by conducting routine call studies and consider member satisfaction survey results, member grievances and appeals related to access, site-specific surveys/audits, and out-of-network requests. Results are analyzed and interventions, such as provider re-education and additional call studies, are implemented to address identified deficiencies.

The MCOs maintain Provider Directories that are available in print versions and online. Activities to validate the provider information in the directories include routine call studies, provider outreach campaigns, reviewing information obtained through

credentialing processes, etc. Review of the directories revealed that all the plans include the required provider information (names, addresses, office hours, etc.); however, issues were noted in that ATC's online "Find a Provider" tool and Humana's online "Find a Doctor" tool did not include specific, contractually required statements.

The health plans ensure their networks can serve members with diverse cultural and linguistic needs as well as physical limitations. This is accomplished by collecting and evaluating member and provider demographic and language information, educating providers about cultural competency, providing cultural competency resources on MCO websites, analyzing grievances related to member cultural and linguistic needs, providing language services, and providing member materials in alternate formats and languages.

Provider Access and Availability Study

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

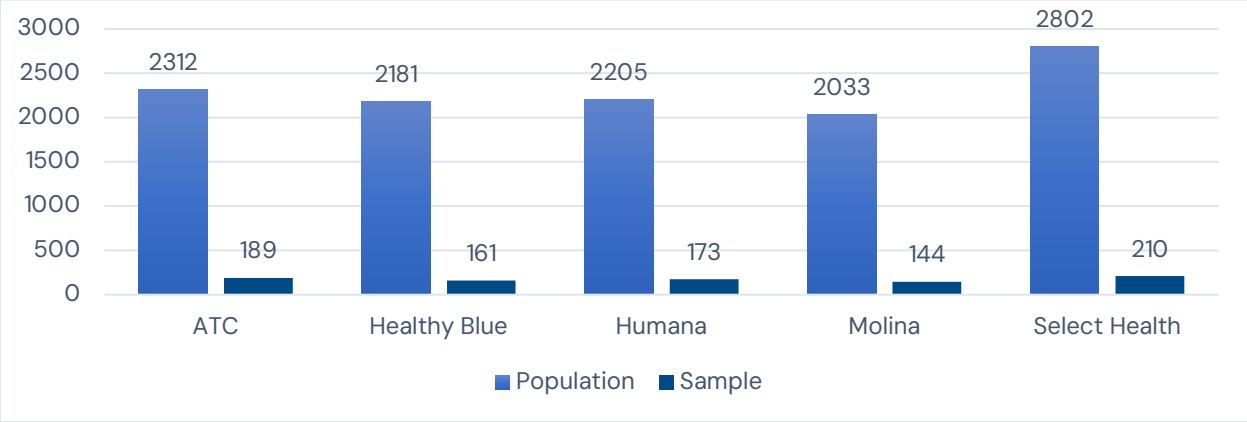
As a part of the annual review process for all plans, Constellation Quality Health conducted a Telephonic Provider Access Study focusing on PCPs. For the study, Constellation Quality Health requested and received a list of network providers and their contact information from each of the health plans. From each list, Constellation Quality Health defined a population of PCPs and selected a statistically relevant sample for the study. Constellation Quality Health attempted to contact these providers to ask a series of questions about the access plan members have to their PCPs.

The following charts summarize the Provider Access and Availability Study findings and compare the five plans surveyed as of this report.

Population and Sample Size

For the five MCOs reviewed, Constellation identified a total population of 11,533 PCPs. From each plan's population, Constellation randomly selected a total of 877 providers, as shown in *Figure 3: Population and Sample Sizes for Each Plan*.

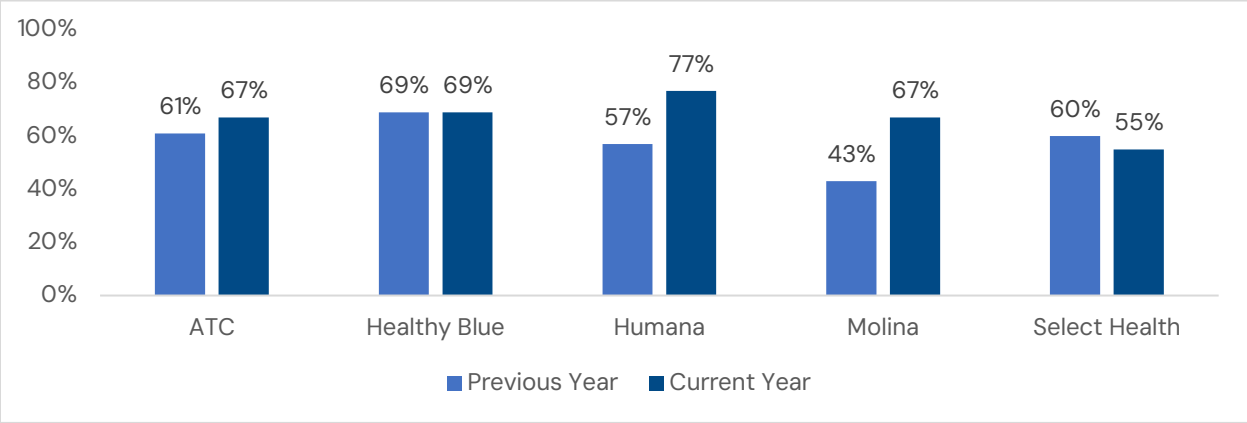
Figure 3: Population and Sample Sizes for Each Plan



Successfully Answered Calls

The percentage of successfully answered calls ranges from 55% to 77% for the five plans. As shown in *Figure 4*, the largest improvement over last year's study was a 24% increase (Molina). ATC and Humana also showed improvement in the successful call rate over the previous year, and Healthy Blue sustained the successful call rate from the previous year. Select Health showed a decline from the previous year.

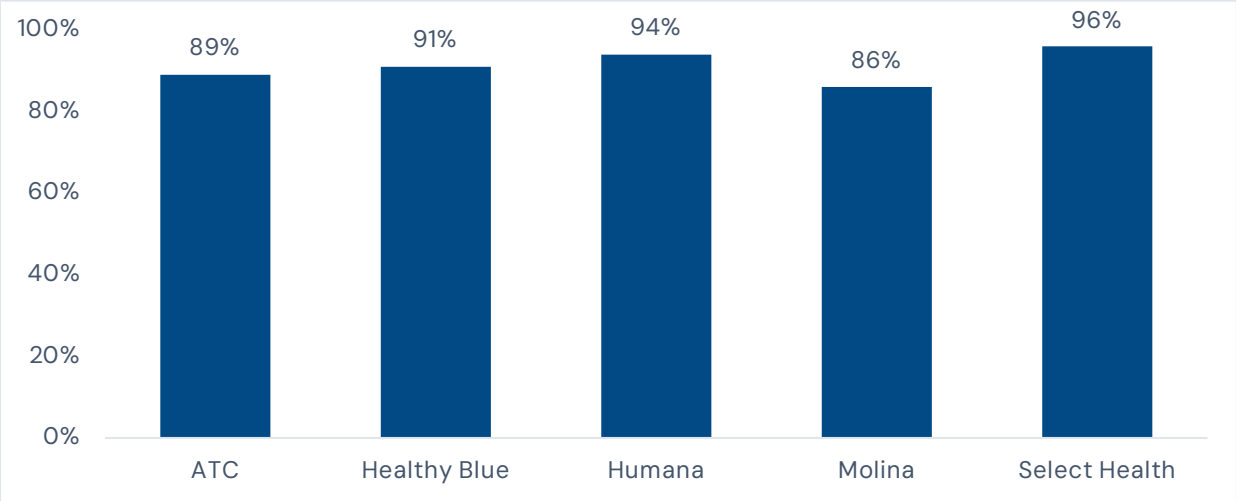
Figure 4: Percentage of Successfully Answered Calls



Currently Accepting the Plan

The range of providers reporting that they accept the plan was 86% to 96%. See *Figure 5: Percentage of Providers Accepting the Plan*.

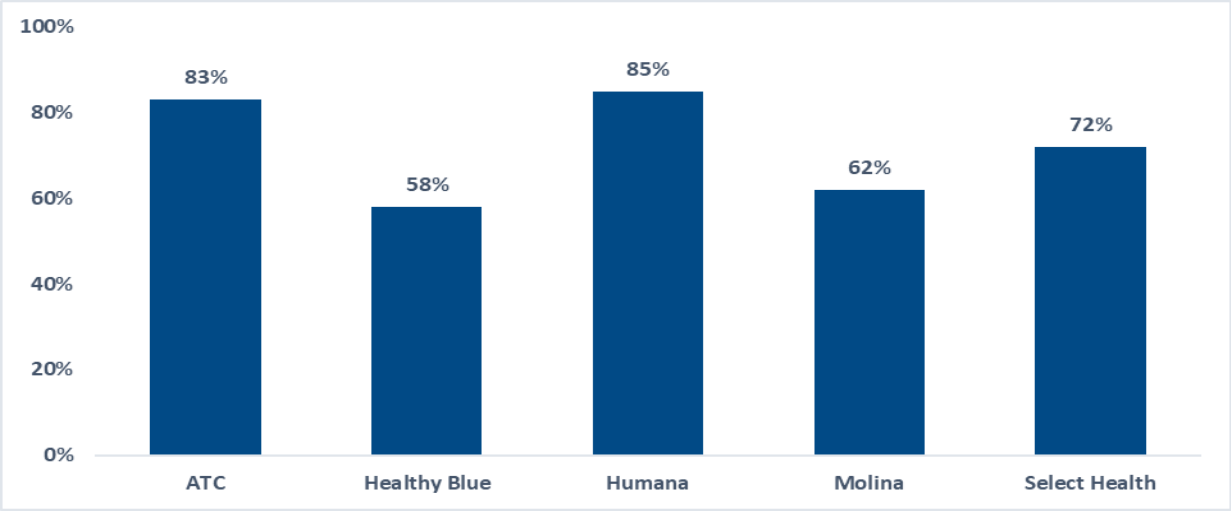
Figure 5: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

Accepting new patients varied from 58% to 85% among the five plans. While three plans saw an improvement compared to the previous year, two experienced a decline. This highlights an opportunity for enhancement by expanding panel capacity to accommodate new Medicaid patients. See *Figure 6: Percentage of Providers Accepting Medicaid Patients*.

Figure 6: Percentage of Providers Accepting Medicaid Patients

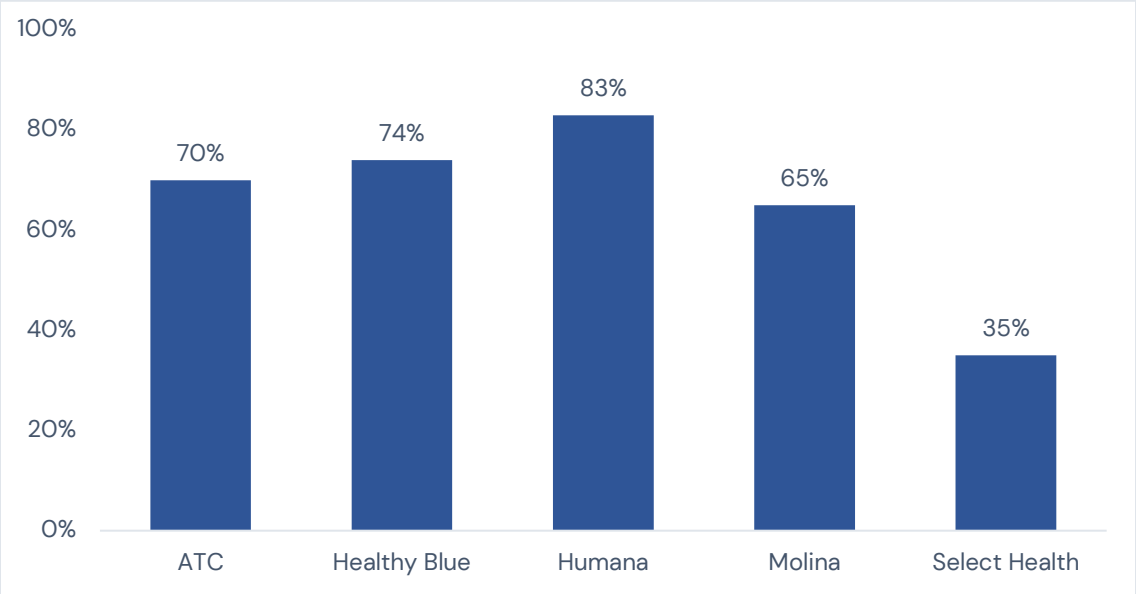


Appointment Availability

Routine appointment availability varied from 35% to 83% among the five plans, indicating all plans were below 85%. This highlights an opportunity for improving timely access to

care for new Medicaid patients. See *Figure 7: Providers with Appointment Availability within Contract Requirements*.

Figure 7: Providers with Appointment Availability within Contract Requirements

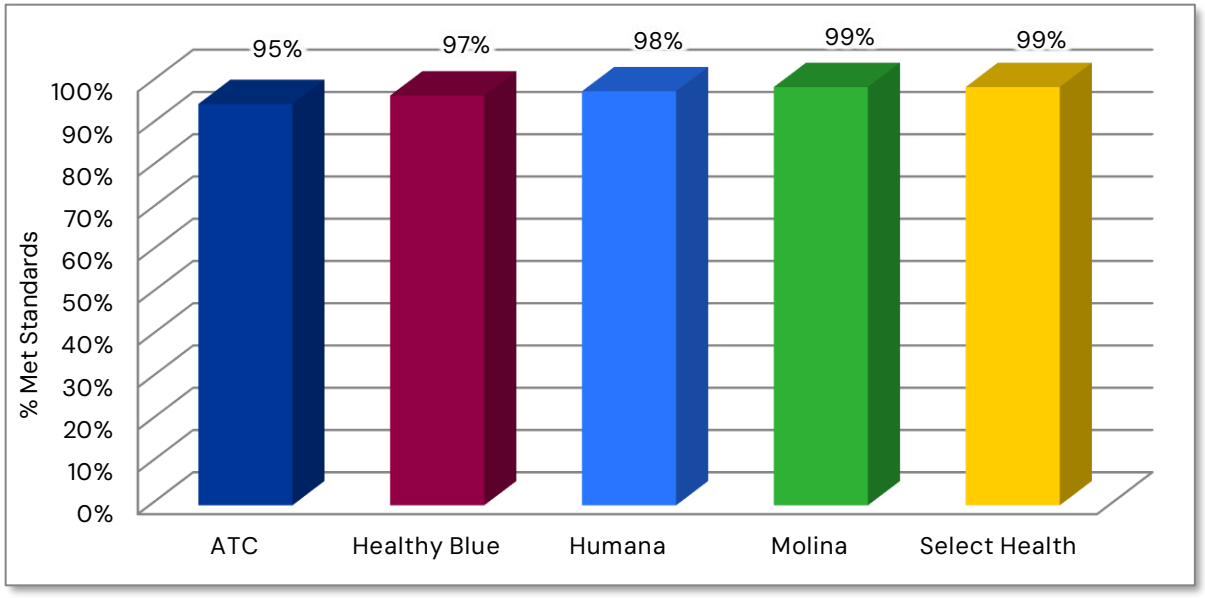


Summary of Study Findings

The results of the telephonic provider access study offered evidence that overall access to providers improved or was sustained at the same rate for four of the five health plans. The percentage of providers that are currently accepting the plans was reported to have a range from 86% to 96%, with the highest rate reported by Select Health. Rates for providers accepting new Medicaid patients demonstrated a range from 58% to 85%. Routine appointment availability varied from 35% to 83% among the five plans.

As noted in *Figure 8: Provider Services Findings*, the percentage of "Met" scores for the review of Provider Services ranged from 95% to 99%. Overall strengths, weaknesses, and recommendations are found in *Table 12* and *Table 13*.

Figure 8: Provider Services Findings



Scores were rounded to the nearest whole number.

Table 12: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Each health plan has a committee to make credentialing and recredentialing decisions for providers that cannot be approved by the Medical Director/Chief Medical Officer.	✓		✓
Credentialing Committees meet routinely and use a peer-review process to make credentialing decisions. A quorum is established prior to making decisions or taking other actions.	✓		
No issues were identified in initial credentialing and recredentialing files for organizational providers.	✓		
Appropriate processes are in place to conduct monthly monitoring to ensure providers are not prohibited from receiving Federal funds.	✓		✓
Four of the five MCOs appropriately document PCP geographic access standards and appointment access standards in policies.			✓
The health plans conduct various activities to formally assess and conduct ongoing monitoring of network adequacy and address any identified network gaps.			✓
The MCOs ensure their network providers can meet the cultural, diversity, and language needs of members.			✓
Successful contact rates for provider call studies conducted by Constellation Quality Health improved for four of five MCOs.			✓
Appropriate processes are in place for initial provider orientation and ongoing provider education.	✓		✓
The MCOs adopt, educate providers about, and assess provider compliance with clinical practice and preventive health guidelines.	✓		✓

Strengths	Quality	Timeliness	Access to Care
The MCOs monitor continuity and coordination of care between PCPs and other providers through medical record reviews and monitoring HEDIS and CAHPS survey results.	✓		✓
The health plans educate providers about medical record documentation standards and assess provider compliance through routine medical record audits. Action is taken to address identified issues.	✓		

Table 13: Provider Services Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
ATC and Healthy Blue policies do not address all required credentialing elements. Humana's policy incompletely addressed appeals of credentialing determinations.	Ensure credentialing processes and requirements are fully documented in applicable policies and procedures.	✓		
Three of the five health plans were noted to have limited external providers on their Credentialing Committees.	Continue efforts to recruit additional external providers, particularly specialty providers, for membership of health plan Credentialing Committees.	✓		
Review of credentialing and recredentialing files revealed issues related to verification of admitting privileges (Humana, Molina, Select Health), verification of CLIA (Humana), and collection of nurse practitioner collaborative agreements (Humana).	Ensure credentialing and recredentialing files include all required elements.	✓		✓
For ATC, documentation of the geographic access standards for primary care and specialty providers was not located in any policy.	Ensure geographic access standards for primary care and specialty providers are thoroughly documented in policy.			✓
Healthy Blue's Network Analyses for Driving Time and Driving Distance report did not include all required Status 1 provider types.	Ensure Geo Access mapping includes all required Status 1 provider types, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2*.			✓
For Molina, multiple issues were noted with documentation of specialty care appointments in policy, the Provider Manual, and Member Handbook.	Ensure specialty appointment access standards are thoroughly and correctly documented in policies, Provider Manuals, and Member Handbooks.			✓
Two of the five MCOs did not include contractually required information in their online "find a provider" search tools.	Ensure all contractually required information is posted in online "find a provider" search tools.			✓

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Appointment availability for routine appointments was below 85% for all five health plans	Educate providers on requirements for appointment availability during touchpoints.			✓
The percentage of providers accepting new Medicaid patients was at or below 85% for all five health plans. For two plans, there was a decline from the previous call study in the percentage of providers who accept new patients.	Determine ways to increase panels for providers; increase providers at locations to ensure new members are able to be added to provider panels.			✓

PROVIDER SERVICES

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*					
The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met ↓	Partially Met ↓	Met	Met	Met
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	Met↑	Met	Met	Met	Met
The credentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met
Work history	Met	Met	Met	Met	Met
Malpractice claims history	Met	Met	Met	Met	Met
Formal application with attestation statement	Met	Met	Met	Met	Met
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
Query of System for Award Management (SAM)	Met	Met	Met	Met	Met
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met
Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Met	Met	Met	Met
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met
Query of Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Met	Met	Met	Met
Additional Requirements for Nurse Practitioners	Met	*	Not Met ↓	*	Met
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met
Recredentialing conducted at least every 36 months	Met	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met
Board certification if claimed by the applicant	Met	Met	Met	Met	Met
Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met
Practitioner attestation statement	Met	Met	Met	Met	Met
Requery the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
Requery of System for Award Management (SAM)	Met	Met	Met	Met	Met
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met
Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Met	Met	Met	Met
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met
Query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Met	Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met
In good standing at the hospitals designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met
Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Met	Met	Met	Met
Additional Requirements for Nurse Practitioners	Met	*	Met	*	Met
Review of practitioner profiling activities	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Met	Met	Met	Met
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Met	Met	Met	Met
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Met	Met	Met	Met
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)*					
The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: Members have a primary care physician located within a 30-mile radius of their residence	Partially Met ↓	Met	Met	Met	Met
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 ↓	Partially Met ↓	Met	Met	Met↑
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Met	Met	Met	Met	Met
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Met	Met	Met
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met
The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy	Met	Met	Met	Met	Met
Practitioner Accessibility The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Met ↑	Met	Partially Met ↓	Met↑
The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards	Met	*	Met	*	Met
The MCO regularly maintains and makes available a Provider Directory that includes all required elements	Partially Met ↓	*	Partially Met ↓	*	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The MCO conducts appropriate activities to validate Provider Directory information	Met	*	Met	*	Met
The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results	Met	Met	Met	Met ↑	Not Met ↓
The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy"	Met	*	Met	*	Met
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*					
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met ↑	Met	Met
Initial provider education includes: MCO structure and health care programs	Met	Met	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met	Met	Met
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Met	Met	Met	Met
Procedure for referral to a specialist	Met	Met	Met	Met	Met
Accessibility standards, including 24/7 access	Met	Met	Met	Met	Met
Recommended standards of care	Met	Met	Met	Met	Met
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met	Met
Provider and member grievance and appeal procedures	Met	Met	Met	Met	Met
Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met	Met	Met	Met
Reassignment of a member to another PCP	Met	Met	Met ↑	Met	Met
Medical record documentation requirements	Met	Met	Met	Met	Met
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	Met	Met	Met	Met
Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*					
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	Met	Met	Met	Met	Met
The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The guidelines include, at a minimum, the following if relevant to member demographics: Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Met	Met	Met	Met
Recommended childhood immunizations	Met	Met	Met	Met	Met
Pregnancy care	Met	Met	Met	Met	Met
Adult screening recommendations at specified intervals	Met	Met	Met	Met	Met
Elderly screening recommendations at specified intervals	Met	Met	Met	Met	Met
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met
Behavioral health services	Met	Met	Met	Met	Met
Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*					
The MCO monitors continuity and coordination of care between PCPs and other providers	Met	Met	Met	Met	Met
Practitioner Medical Records					
The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians	Met	Met	Met	Met	Met
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Met	Met	Met	Met
Medical Record Audit The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met	Met
Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	Met	Met	Met	Met

** New Standards added after the EQR was completed.*

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

Each MCO emphasizes their commitment that all members are treated in a manner that acknowledges their rights and responsibilities by including notification steps in policy and providing member rights and responsibilities in Member Handbooks, Provider Manuals, welcome kits, and on health plan websites. ATC's Member Rights and Responsibilities Policy (SC.MBRS.25) does not include all member rights required by the *SCDHHS Contract, Section 3.15.4.6*.

Members receive new member packets, which are mailed within 14 calendar days from the date the MCO receives the member's enrollment data. The Member Handbook and other member materials provide information members need to understand, including benefits, covered services, applicable copayments, and health plan processes. Members are notified in writing 30 days before the effective date of changes to services and benefits.

The EQRs concluded that each MCO provides written member materials in alternative formats and in consideration of special needs, disabilities, or for members with limited English speaking and reading proficiency. Each MCO defines behavioral health, physical health, and emergency services and provides clear information about the appropriate use of service types.

Member Handbooks and other member communications provide instructions for obtaining a copy of the Member Handbook annually. Hours of operation, Customer Service numbers, and information about the availability of the 24/7 Nurse Advice Line is provided throughout Member Handbooks and websites. Disenrollment information is included in Member Handbooks, Provider Manuals, websites, and in policies.

Member Satisfaction Survey

ATC contracts with Press Ganey, a certified vendor, to conduct adult and child member satisfaction surveys. For MY2022, the adult response rate improved from the previous year's response rate. Findings showed improvement in the ratings of customer service, coordination of care, rating of specialist, getting care quickly, and rating of personal doctor. The largest decline was in the rating of health care. The child response rate also increased over the previous year's rate. Improvement occurred for the rating of health plan. The largest decline was in getting care quickly. The child with chronic conditions (CCC) response rate improved over the previous year's rate, and the rating of health plan, coordination of care, and the rating of specialist improved. The largest decline for the CCC population was related to customer service.

Healthy Blue contracts with Center for the Study of Services, a certified CAHPS survey vendor, to conduct child and adult member satisfaction surveys. Results of the satisfaction surveys are

presented to the Quality Improvement Committee (QIC) and network providers. The analysis and implementation of interventions to improve member satisfaction are discussed during the committee meetings.

Humana's member satisfaction survey for MY2022 found the adult response rate was 12.6%, an improvement from the previous year's response rate of 5.1%. For year-over-year trending, improvement was demonstrated in rating of health plan, rating of health care, and flu vaccine. The largest decline was for getting care quickly. The child response rate was 6.8%, a decline over last year's rate of 7.9%. Improvement occurred for rating of health plan, getting needed care, customer service, rating of health care, getting care quickly, and how well doctors communicate. The largest decline was noted for the rating of specialists. The child CCC response rate was 6%, an improvement over the previous year's rate of 5.4%. For the CCC population, the highest rated domain was getting care quickly. The improvement and decline evaluation are not performed due to a reported sample size of zero for several domains last year.

Molina's adult survey had 245 responses out of 1687 surveys, a 14.5% response rate, which is a decline from the previous response rate of 18.1%. Benchmarks (66.7th Quality Compass (QC) percentile) were met for seven out of 10 measures. For the child survey, there were 353 responses out of 3640 surveys for a response rate of 9.7%. This is a decline from the previous year's rate of 13.1%. The benchmark rate (66.7th QC benchmark) was met for three out of nine measures. For the CCC survey, there were 237 completed surveys out of a total of 2397, for a response rate of 9.9%. This is a decline from the previous year's rate of 12.7%. The benchmark (66.7th QC percentile) was met for five out of nine measures.

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 CCC 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.

Grievances

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

Processes for filing and handling grievances are detailed in policies, Member Handbooks, Provider Manuals, and on each health plan's website. Timelines for grievance acknowledgment, resolution, and extensions, if needed, are clearly described. Grievances are logged and categorized

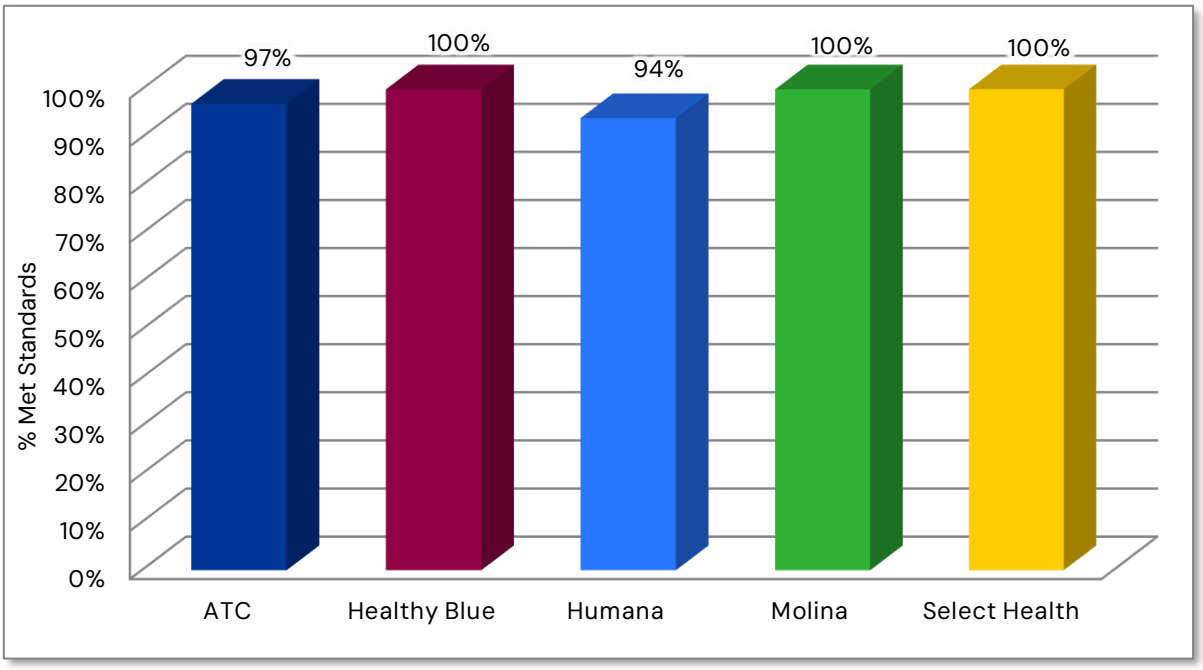
appropriately. Trends are reported quarterly as reflected in the minutes of internal quality committees.

Discrepancies were noted in the timeframe for grievance acknowledgement in Humana's policies, Member Handbook and Provider Manual. Humana's grievance acknowledgement letters did not indicate that a grievance may be filed if the member disagrees with the health plan's request for an extension.

Of the grievance file sample reviewed for the EQRs, almost all grievances were resolved timely. Some of Humana's grievance files were closed with significant time remaining and members were instructed to contact the health plan to provide further information.

Three of five MCOs received "Met" scores for 100% of the Member Services standards for the 2023 EQR.

Figure 9: Member Services Findings



Scores were rounded to the nearest whole number.

Table 14: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members are informed of their rights and responsibilities through Member Handbooks, newsletters, and health plan websites.	✓		

Strengths	Quality	Timeliness	Access to Care
The Member Handbook is a comprehensive resource for members to understand their benefits and health plan services and processes.			✓
Each health plan ensures member materials are understandable and available in alternate formats as needed to meet member needs.			✓
Various communication strategies are used to provide information about programs and services and to encourage members to get recommended preventive services. These include welcome packets, telephonic outreach, email, automated text messages and calls, newsletters, etc.			✓
Member satisfaction results are examined internally.	✓		
For the 2023 EQR, the sample of grievance files reviewed for three health plans reflected timely resolution.		✓	

Table 15: Member Services Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
ATC's policy did not include all member rights.	Include all member rights and responsibilities outlined in the *SCDHHS Contract* in policy.	✓		✓
Discrepancies were noted in Humana's policies, Member Handbook, and Provider Manual regarding the timeframe for grievance acknowledgement.	Verify the timeframe for acknowledging a grievance and include the correct timeframe in all materials.		✓	
Humana's grievance acknowledgement letters did not indicate that a grievance may be filed if the member disagrees with the health plan's request for an extension.	Include the notification that a member may file a grievance if they disagree with the health plan's request for an extension in the acknowledgement letter.	✓		
Some of Humana's grievance files were closed with significant time remaining and members were instructed to contact the health plan to provide further information.	Establish processes or training to ensure that grievances are not closed with significant time remaining when additional information is needed.		✓	

MEMBER SERVICES

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*					
The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities	Met	Met	Met	Met	Met
Member rights include, but are not limited to, the right: • To be treated with respect and with due consideration for dignity and privacy • To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand • To participate in decision-making regarding their health care, including the right to refuse treatment • 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 • 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 • 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	Partially Met ↓	Met	Met	Met	Met
Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: • Benefits and services included and excluded in coverage • Direct access for female members to a women's health specialist in addition to a Primary Care Provider (PCP) • Access to second opinions at no cost, including use of an out-of-network provider if necessary • How members may obtain benefits, including family planning services from out-of-network providers • Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefit • Any requirements for prior approval of medical or behavioral health care and services	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
• Procedures for and restrictions on obtaining out-of-network medical care • Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services • Policies and procedures for accessing specialty care • Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions • Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network • Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care • Procedures for disenrolling from the MCO • Procedures for filing grievances and appeals, including the right to request a State Fair Hearing • 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 • Instructions on how to request interpretation and translation services at no cost to the member • Member's rights, responsibilities, and protections • Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them • A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services • How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary • Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services • A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive • Information on how to report suspected fraud or abuse • Additional information as required by the contract and/or federal regulation					
Members are notified at least once per year of their right to request a Member Handbook or Provider Directory	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Members are informed in writing of changes in benefits and changes to the provider network	Met	Met	Met	Met	Met
Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met	Met	Met	Met	Met
The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO	Met	Met	Met	Met	Met
Member Enrollment and Disenrollment *42 CFR § 438.56*					
The MCO enables each member to choose a PCP upon enrollment and assists, if needed	Met	Met	Met	Met	Met
MCO-initiated member disenrollment requests are compliant with contractual requirements	Met	Met	Met	Met	Met
Preventive Health and Chronic Disease Management Education					
The MCO informs members of available preventive health and disease management services and encourages members to utilize these services	Met	Met	Met	Met	Met
The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met
The MCO provides education to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care	Met	Met	Met	Met	Met
Member Satisfaction Survey					
The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	Met	Met	Met	Met	Met
Statistically sound methodology, including probability sampling to ensure it is representative of the total membership	Met	Met	Met	Met	Met
The availability and accessibility of health care practitioners and services	Met	Met	Met	Met	Met
The quality of health care received from MCO providers	Met	Met	Met	Met	Met
The scope of benefits and services	Met	Met	Met	Met	Met
Claim processing procedures	Met	Met	Met	Met	Met
Adverse MCO claim decisions	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The MCO analyzes data obtained from the member satisfaction survey to identify quality issues	Met	Met	Met	Met	Met
The MCO implements significant measures to address quality issues identified through the member satisfaction survey	Met	Met	Met	Met	Met
The MCO reports the results of the member satisfaction survey to providers	Met	Met	Met	Met	Met
The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee	Met	Met	Met	Met	Met
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*					
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	Met	Met	Met	Met	Met
The definition of a grievance and who may file a grievance	Met	Met	Met ↑	Met	Met
Procedures for filing and handling a grievance	Met	Met	Partially Met	Met	Met
Timeliness guidelines for resolution of a grievance	Met	Met	Met	Met	Met
Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee	Met	Met	Met	Met	Met
Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Met	Met	Met	Met	Met
The MCO applies grievance policies and procedures as formulated	Met	Met↑	Partially Met	Met	Met
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met

D. Quality Improvement

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

The Quality Improvement (QI) Programs developed by the MCOs focus on the health care and services their members receive and include all aspects of health care quality. Each health plan provided a copy of their QI Program Description, which included specific goals, objectives, and priorities to help achieve their overall goals. Information about the QI Program is shared with providers and members through each health plan's website and in Provider Manuals and Member Handbooks.

Annually, the health plans develop QI work plans to identify and track planned QI activities. Constellation Quality Health received the 2022 and 2023 QI Work Plans for each health plan. Both work plans included the yearly QI activities, the individuals responsible for each task, target dates, updates, and any previously identified issues. Molina's 2023 QI Work Plan includes the ability to trend data over five years. The results columns are labeled Y1, Y2, Y3, Y4, and Y5. Molina indicated that calendar year 2023 will be considered the first year for this trending activity. Constellation Quality Health questioned this new format and its relation to how new activities added during the five-year period would be displayed or denoted as year one. Also, there were several errors and/or missing information in the 2023 QI Work Plan.

Humana's QI Work Plans also contained errors and/or missing information. The Quality Assurance Committee was incorrectly referenced as the Quality Assessment Committee and as the Quality Assessment and Performance Improvement Committee. In the 2023 Work Plan, the goal for the NICU activity states, "Track and trend average length of stay." However, the average length of stay is not being reported. The number of NICU admissions and the follow-up provided by Case Management was being reported. The Performance Improvement Projects section was incomplete.

The MCO's have established QI committees charged with oversight of the QI Program. The QI committees act as oversight committees and receive regular reports from other departments and/or subcommittees that are accountable to the committee. Members of these committees include the health plans' Chief Medial Officers or Medical Directors, quality leads, senior managers, and other staff responsible for key functions within the organization. Participating network providers with a wide variety of specialties serve as voting members. Humana's QI Committee lacked network provider participation as required by the *SCDHHS Contract, Section 15.3.1*. This was an issue identified during the 2022 and 2023 EQRs and not corrected.

Minutes are documented for each meeting and presented to the committee for review and approval at the next scheduled meeting. Humana's QI committee charter indicated voting members are expected to attend each meeting or appoint a representative in their absence. The committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings. After the onsite, Humana submitted another copy of the QI

committee meeting minutes for meetings held in 2023. It was noted that for the August 2023 meeting, the voting members' attendance had changed. The Compliance Lead, the Clinical Pharmacy Director, and the OB/GYN External Physician were marked as present in the committee meeting minutes submitted after the onsite. These voting members were noted as absent in the meeting minutes submitted with the desk materials. Also, an External Physician (pediatrician) was noted as absent in the meeting minutes submitted after the onsite. There was no documentation indicating why the attendance was changed and the minutes amended.

Each MCO provides direct feedback on provider performance by generating reports and dashboards. Examples of the information included in these reports include the practitioner's performance on key quality measures member data profiles, Emergency Department (ED) visit utilization, HEDIS gaps in care, and data trends.

An annual review of the overall effectiveness of the QI Programs is conducted by each MCO. The results of the annual evaluations are used to develop and prioritize the next year's activities. ATC, Healthy Blue, Humana, and Select Health submitted the 2022 QI Program Evaluations, and Molina submitted the 2021 QI Program Evaluation. Each of the Program Evaluations contained the annual analysis of the QI Programs with barriers, interventions, and conclusions or recommendations for each activity. Humana's QI Program Evaluation was missing data or results, and incorrect goals were being measured. These were previously identified issues that were not corrected.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation Quality Health conducted a validation review of the HEDIS measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid. The Performance Measure (PM) Validation found that all the health plans were 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 (MY 2021/2022), the previous measure year (MY2021/2022), and the change from the current to previous year are reported in *Table 16: HEDIS Performance Measure* Results. Rates shown in green indicate a substantial improvement (>10%), and the rates shown in red indicate a substantial decline (>10%). Due to timing of the reviews, MY2021 data are presented for Healthy Blue and Molina, and MY2022 data are presented for ATC, Humana, and Select Health.

Table 16: HEDIS Performance Measure Results

Measure/Data Element	ATC (MY 2022)	Healthy Blue (MY 2021)	Humana (MY 2022)	Molina (MY 2021)	Select Health (MY 2022)	Statewide Average
Effectiveness of Care: Prevention and Screening						
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)						
BMI Percentile	73.48%	75.43%	71.05%	70.56%	70.34%	72.17%
Counseling for Nutrition	61.80%	65.45%	58.39%	58.88%	59.32%	60.77%
Counseling for Physical Activity	57.42%	61.56%	55.96%	56.2%	57.06%	57.64%
Childhood Immunization Status (cis)						
DTaP	65.21%	67.88%	31.25%	64.96%	73.48%	60.56%
IPV	82.97%	84.91%	43.75%	82.73%	87.59%	76.39%
MMR	82.97%	81.75%	54.17%	82.97%	87.59%	77.89%
HiB	80.05%	79.32%	43.75%	76.4%	82.24%	72.35%
Hepatitis B	82.00%	82.97%	41.67%	80.78%	87.35%	74.95%
VZV	82.73%	83.45%	54.17%	80.29%	86.13%	77.35%
Pneumococcal Conjugate	69.83%	72.26%	37.50%	67.4%	73.24%	64.05%
Hepatitis A	83.21%	80.54%	52.08%	79.81%	86.62%	76.45%
Rotavirus	70.07%	71.05%	33.33%	69.34%	71.05%	62.97%
Influenza	30.17%	35.52%	6.25%	35.28%	33.09%	28.06%
Combination #3	59.61%	62.04%	27.08%	58.88%	64.72%	54.47%
Combination #7	53.53%	54.26%	25.00%	53.28%	55.96%	48.41%
Combination #10	21.41%	27.98%	4.17%	25.79%	26.52%	21.17%
Immunizations for Adolescents (ima)						
Meningococcal	70.07%	67.40%	50.00%	66.67%	77.37%	66.30%
Tdap/Td	83.70%	75.91%	57.69%	77.37%	86.62%	76.26%
Combination #1	70.07%	66.42%	50.00%	66.42%	76.64%	65.91%
Combination #2	29.93%	28.47%	11.54%	28.95%	36.50%	27.08%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	30.17%	29.44%	11.54%	29.44%	37.71%	27.66%
Lead Screening in Children (lsc)	60.30%	65.31%	35.42%	67.4%	65.85%	58.86%
Breast Cancer Screening (bcs)	52.18%	49.23%	0.00*	52.36%	56.18%	52.49%
Cervical Cancer Screening (ccs)	56.93%	57.54%	31.39%	62.53%	62.28%	54.13%
Colorectal Cancer Screening (COL)	36.77%	NR	20.00%*	NR	40.56%	38.67%
Chlamydia Screening in Women (chl)						
Total	61.17%	56.76%	56.83%	57.78%	60.29%	58.57%
Effectiveness of Care: Respiratory Conditions						
Appropriate Testing for Children with Pharyngitis (cwp)						
Total	80.32%	75.74%	82.35%	71.59%	82.40%	78.48%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	22.83%	25%	NR	25.66%	29.93%	25.86%

Measure/Data Element	ATC (MY 2022)	Healthy Blue (MY 2021)	Humana (MY 2022)	Molina (MY 2021)	Select Health (MY 2022)	Statewide Average
Pharmacotherapy Management of COPD Exacerbation (pce)						
Systemic Corticosteroid	70.16%	68.79%	78.79%	65.36%	70.53%	70.73%
Bronchodilator	79.76%	81.09%	75.76%	78.01%	79.57%	78.84%
Asthma Medication Ratio (amr)						
Total	62.17%	72.65%	NR	63.15%	70.32%	67.07%
Effectiveness of Care: Cardiovascular Conditions						
Controlling High Blood Pressure (cbp)	56.69%	54.74%	63.41%	59.85%	52.01%	57.34%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	75.34%	72.34%	0.00%*	68.18%	66.67%	70.63%
Statin Therapy for Patients With Cardiovascular Disease (spc)						
Received Statin Therapy - Total	80.18%	79.54%	100%*	82.21%	81.65%	80.90%
Statin Adherence 80% - Total	57.64%	56.25%	0.00%*	54.53%	62.14%	57.64%
Cardiac Rehabilitation (CRE)						
Cardiac Rehabilitation - Initiation (Total)	3.10%	3.27%	0.00%*	2.65%	2.99%	80.90%
Cardiac Rehabilitation - Engagement1 (Total)	5.75%	2.34%	0.00%*	5.31%	4.27%	57.64%
Cardiac Rehabilitation - Engagement2 (Total)	5.75%	2.34%	0.00%*	4.87%	4.27%	80.90%
Cardiac Rehabilitation - Achievement (Total)	2.65%	0.47%	0.00%*	3.1%	1.71%	57.64%
Effectiveness of Care: Diabetes						
Hemoglobin A1c Control for Patients With Diabetes (hbd)						
HbA1c Poor Control (>9.0%)	39.66%	41.61%	49.72%	45.5%	50.85%	45.47%
HbA1c Control (<8.0%)	51.82%	50.12%	39.11%	46.72%	42.09%	45.97%
Eye Exam (Retinal) Performed	42.34%	35.77%	36.46%	51.58%	47.45%	42.72%
Blood Pressure Control (<140/90 mm Hg)	56.69%	58.39%	61.67%	61.31%	61.31%	59.52%
Kidney Health Evaluation for Patients With Diabetes (ked)						
Kidney Health Evaluation for Patients With Diabetes (Total)	25.81%	23.53%	20.88%	24.79%	24.53%	23.91%
Statin Therapy for Patients With Diabetes (spd)						
Received Statin Therapy	63.26%	62.54%	NR	64.14%	60.41%	62.59%
Statin Adherence 80%	51.65%	54.57%	NR	49.73%	56.29%	53.06%
Effectiveness of Care: Behavioral Health						
Antidepressant Medication Management (amm)						
Effective Acute Phase Treatment	45.03%	49.08%	61.76%	47.18%	48.26%	50.26%
Effective Continuation Phase Treatment	28.59%	32.17%	29.41%	30.82%	30.14%	30.23%
Follow-Up Care for Children Prescribed ADHD Medication (add)						
Initiation Phase	46.10%	32.56%	50.00%*	34.48%	42.49%	38.91%
Continuation and Maintenance (C&M) Phase	59.91%	48.12%	NR	45.5%	57.05%	52.65%
Follow-Up After Hospitalization for Mental Illness (fuh)						
Total - 30-Day Follow-Up	62.96%	62.14%	45.00%	59.68%	64.36%	58.83%
Total - 7-Day Follow-Up	42.41%	40.88%	27.50%	38.22%	38.24%	37.45%

Measure/Data Element	ATC (MY 2022)	Healthy Blue (MY 2021)	Humana (MY 2022)	Molina (MY 2021)	Select Health (MY 2022)	Statewide Average
Follow-Up After Emergency Department Visit for Mental Illness (fum)						
Total - 30-Day Follow-Up	52.76%	54.43%	40.32%	57.95%	61.33%	53.36%
Total - 7-Day Follow-Up	40.56%	39%	29.03%	42.19%	46.58%	39.47%
Diagnosed Substance Use Disorders (DSU)						
Diagnosed Substance Use Disorders - Alcohol (Total)	1.76%	NR	2.81%	NR	1.19%	1.92%
Diagnosed Substance Use Disorders - Opioid (Total)	1.46%	NR	1.70%	NR	1.24%	1.47%
Diagnosed Substance Use Disorders - Other (Total)	2.93%	NR	3.88%	NR	2.48%	3.10%
Diagnosed Substance Use Disorders - Any (Total)	4.89%	NR	6.30%	NR	3.94%	5.04%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)						
Total - 30-Day Follow-Up	34.97%	36.89%	40.00%*	36%	36.47%	36.08%
Total - 7-Day Follow-Up	21.39%	23.95%	25.00%*	25.2%	20.58%	22.78%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)						
30-Day Follow-Up: Total	26.07%	17.73%	20.69%	16.25%	27.83%	21.71%
7-Day Follow-Up: Total	17.38%	13.48%	8.62%	11.31%	18.50%	13.86%
Pharmacotherapy for Opioid Use Disorder (POD)						
Pharmacotherapy for Opioid Use Disorder (Total)	35.31%	38.35%	41.38%	52.55%	32.96%	40.11%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.76%	77.10%	76.60%	79.97%	78.95%	77.68%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	67.59%	60.12%	75.00%*	66.82%	62.99%	64.38%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	80.00%*	50.00%	NR	93.75%	58.33%	67.36%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	64.36%	59.10%	66.67%*	64.03%	60.76%	62.06%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)						
Blood glucose testing - Total	51.71%	54.46%	27.27%*	51.21%	56.22%	53.40%
Cholesterol Testing - Total	30.23%	38.22%	18.18%*	28.64%	37.05%	33.54%
Blood glucose and Cholesterol Testing - Total	28.14%	35.99%	18.18%*	26.94%	34.05%	31.28%
Effectiveness of Care: Overuse/Appropriateness						
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.75%	0.53%	0.00%*	0.57%	0.44%	0.57%
Appropriate Treatment for Children With URI (uri)						
Total	87.90%	88.32%	91.79%	88.28%	88.33%	88.92%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)						
Total	56.45%	54.67%	55.32%	50.62%	54.71%	54.35%
Use of Imaging Studies for Low Back Pain (lbp)	69.37%	54.67%	70.37%	68.69%	71.25%	66.87%
Use of Opioids at High Dosage (hdo)	3.82%	2.74%	1.67%	1.74%	3.95%	2.78%
Use of Opioids From Multiple Providers (uop)						

Measure/Data Element	ATC (MY 2022)	Healthy Blue (MY 2021)	Humana (MY 2022)	Molina (MY 2021)	Select Health (MY 2022)	Statewide Average
Multiple Prescribers	17.38%	18.94%	35.23%	23.24%	19.74%	22.91%
Multiple Pharmacies	1.24%	1.27%	0.00%	1.96%	2.06%	1.31%
Multiple Prescribers and Multiple Pharmacies	1.01%	0.83%	0.00%	1.39%	1.48%	0.94%
Risk of Continued Opioid Use (cou)						
Total - >=15 Days covered	3.58%	3.01%	9.15%	4.1%	3.03%	4.57%
Total - >=31 Days covered	2.12%	2.16%	5.63%	2.6%	1.07%	2.72%
Access/Availability of Care						
Adults' Access to Preventive/Ambulatory Health Services (aap)						
Total	72.46%	76.10%	69.08%	79.16%	76.00%	74.56%
Initiation and Engagement of AOD Dependence Treatment (iet)						
Initiation of AOD Treatment: Total	42.34%	41.81%	41.98%	41.83%	39.25%	41.44%
Engagement of AOD Treatment: Total	10.67%	13.22%	11.11%	12.27%	10.63%	11.58%
Prenatal and Postpartum Care (ppc)						
Timeliness of Prenatal Care	84.43%	89.54%	92.70%	87.83%	89.19%	88.74%
Postpartum Care	71.29%	75.91%	72.06%	75.67%	76.01%	74.19%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)						
Total	58.97%	64.86%	33.33%	54.5%	61.54%	54.64%
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)	53.35%	55.06%	8.45%	57.31%	55.47%	45.93%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	65.07%	68.29%	41.67%*	69.27%	71.28%	68.48%
Child and Adolescent Well-Care Visits (WCV)						
Child and Adolescent Well-Care Visits (Total)	41.67%	42.66%	28.70%	44.11%	46.78%	40.78%

*Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator, * denominator less than thirty (30).*

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

ATC submitted two PIPs regarding Hospital Readmissions and Adult Access to Preventive Care for validation. The results of the validation for those PIPS follow.

Table 17: ATC's Hospital Readmissions PIP

Hospital Readmissions	
The Hospital Readmissions PIP aims to reduce the annual rate of readmissions within 30 days for 18- to 64-year-old patients. This PIP has three measurement periods. The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge was 18.0%, which reduced to 16.2% in 2021, then to 15.5% in 2022. The rate has met the benchmark.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care (TOC) team assesses members upon discharge and reviews the discharge summary, assists member with scheduling appointment within seven days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meet quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. • UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met.	

Table 18: ATC's Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The PIP showed improvement in the rate from MY2020 at 77.28% to MY2021 at 78.18%. The benchmark is 81.97%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Adult Access to Preventive Health Care (AAP)
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well-versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • Eliza application for scheduling appointments and member outreach. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. • Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.

Healthy Blue submitted the Customer Service and Comprehensive Diabetes Care PIPs for validation. Results of that validation follows.

Table 19: Healthy Blue's CAHPS – Customer Service PIP

CAHPS - Customer Service	
The aim for this PIP is to improve the Child CAHPS measure: Customer Service Provided Information/Help. This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass. This PIP showed an improvement in the rate for the percentage of members rating customer service from 81.1% in MY 2020 to 83.8% in MY 2021. The documentation showed interventions addressing the response rate, language barriers, and customer service-related interventions.	
Previous Validation Score	Current Validation Score
88/93= 95% High Confidence in Reported Results	99/99=100% High Confidence in Reported Results
Interventions	
• Oversampling • Provide a Spanish Survey	

Table 20: Healthy Blue's Comprehensive Diabetes Care PIP

Comprehensive Diabetes Care	
The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. The rate for poor control (HbA1C > or = 9) declined from 51.09% for baseline to 41.61% remeasurement one, which is improvement, as the goal is to lower the rate. The retinal eye exam rate increased from 35.52% at baseline to 35.77% at remeasurement one.	
Previous Validation Score	Current Validation Score
93/93= 100% High Confidence in Reported Results	99/99= 100% High Confidence in Reported Results
Interventions	
• Targeted text messages and outreach calls to members who have been diagnosed as being diabetic to ensure the member has their HbA1c screenings and diabetic retinal eye exams. • Members that become compliant on the HbA1c test, eye exam, and completion of diabetes survey will be able to choose gift cards from various platforms. In addition to gift cards, members can receive fresh fruits and vegetables. • Practice Consultants visit providers (via webinar), review their current Gaps in Care, provide a PowerPoint presentation with HEDIS information, and answer any questions that the provider may have. • Case Managers offer members assistance with PCP appointments, pharmacy, and any Social Determinants of Health needs.	

Humana submitted two PIPs: the Human Papillomavirus Vaccine (HPV) PIP and the Prenatal and Postpartum PIP. Both PIPs scored in the "High Confidence in Reported Results" range as noted in the tables that follow. A summary of each PIP's status and the interventions is also included.

Table 21: Human Papillomavirus Vaccine PIP

Human Papillomavirus Vaccine (HPV)	
The HPV vaccine PIP is aimed at increasing HPV vaccines among 9–13-year-olds. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of HPV vaccines. The goal rate for this PIP is 36.5%. The Measure Year (MY) 2021 rate was 1.82% which improved to 3.85% for MY 2022 for the interim rate, with a final rate of 11.5%. This rate includes medical record, supplemental, and administrative data.	
Previous Validation Score	Current Validation Score
79/79=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• HEDIS metric monitoring dashboard to include data monitoring and tracking towards goals. • Clinical dashboard with HEDIS alerts to prompt Case Management staff to educate members on missing preventative services, including vaccines. • Targeted outreach campaigns specific to EPSDT program offerings.	

Human Papillomavirus Vaccine (HPV)
• Well child visit text campaign to support well-child visits with an effort to increase chances of positive provider-member relationship. • Member and Provider newsletters educating providers on HPV vaccine uptake importance. • Member Incentives • Provider Newsletter education related to same day, same way campaign.

Table 22: Prenatal and Postpartum PIP

Prenatal and Postpartum (PPC)	
The aim for the Prenatal and Postpartum PIP is to increase the rate of eligible women receiving timely prenatal and postpartum care. The purpose of this project is to align with state efforts of increasing postpartum compliance in South Carolina by 15% by 2026. There were low denominators for the baseline rates for MY 2021, with a rate of 100% for prenatal care (only three members included in the rate) and 0% for postpartum care (three members in the rate). For MY 2022 interim rates, the results showed 84.49% for prenatal care (goal is 85.4%) and 57.59% (goal is 77.37%) for postpartum care. The final HEDIS rate is noted, however, as 92.7% for prenatal care, and 72.06% for postpartum care. The final MY 2022 rates show that prenatal care is above the goal, and the final rate for postpartum care is below the goal but improving.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Implemented Case Management staffing structure to include a bi-lingual prenatal nurse and reminders. • Data monitoring through Cotiviti at a monthly cadence. • Targeted outreach campaigns specific to Humana Beginnings program offerings. • Provider newsletter educating providers on 12-month postpartum extended coverage. • Value Added Benefits for pregnant members that included car seats and cribs.	

Molina submitted three PIPs for validation. Topics included Improving Encounters Acceptance Rates, Child and Adolescent Well-Care Visits, and Immunizations for Adolescents. All three 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 23: Molina's Improving Encounters Acceptance Rates PIP

Improving Encounters Acceptance Rates	
The Improving Encounters Acceptance Rates PIP examines the rate of professional encounters accepted out of the total paid claims for Molina and the rate of rejections out of the total paid claims. The values are in dollar amounts. For the acceptance rate, there was improvement from remeasurement one at 96.9% to remeasurement two at 97.3% (the refreshed rate shows 98.82%). The goal is 100%. The 837P rejection rate declined from 2.82% to 1.35%, which demonstrated improvement. The goal for this measure is 2%.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	79/79=100% High Confidence in Reported Results
Interventions	
The interventions included a provider crosswalk, review of QNXT claims setup, logic checks, review of rejected encounters, and logic adjustment focusing on billing NPI.	

Table 24: Molina's Immunizations for Adolescents PIP

Immunizations for Adolescents Program	
The Immunizations for Adolescents PIP examines adolescents 13 years of age with one dose of meningococcal vaccine, one tetanus, Tdap, and HPV by their 13th birthday. Molina chose this PIP to target rural and urban areas across SC to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV related cancers. The baseline rate was 28.95% with a slight decline in the administrative rate of 28.35%. The annual improvement goal for this PIP is 31.19%.	
Previous Validation Score	Current Validation Score
72/72=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members.	

Table 25: Molina's Child and Adolescent Well-Care Visits PIP

Child and Adolescent Well-Care Visits	
The aim for the Child and Adolescent Well-Care Visits PIP is to offer eligible members and providers incentives for members receiving a Well-Visit or a Comprehensive Well-Visit (for Ages 3 to 21). This PIP showed a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% at the remeasurement one. The goal is 44.29% for the annual improvement.	
Previous Validation Score	Current Validation Score
72/72=100% High Confidence in Reported Results	73/74=99% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with Logisticare for member transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was developed and placed on the Provider Portal. • Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Select Health submitted two PIPs for validation regarding 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 26: Select Health's Diabetes Outcomes Measures PIP

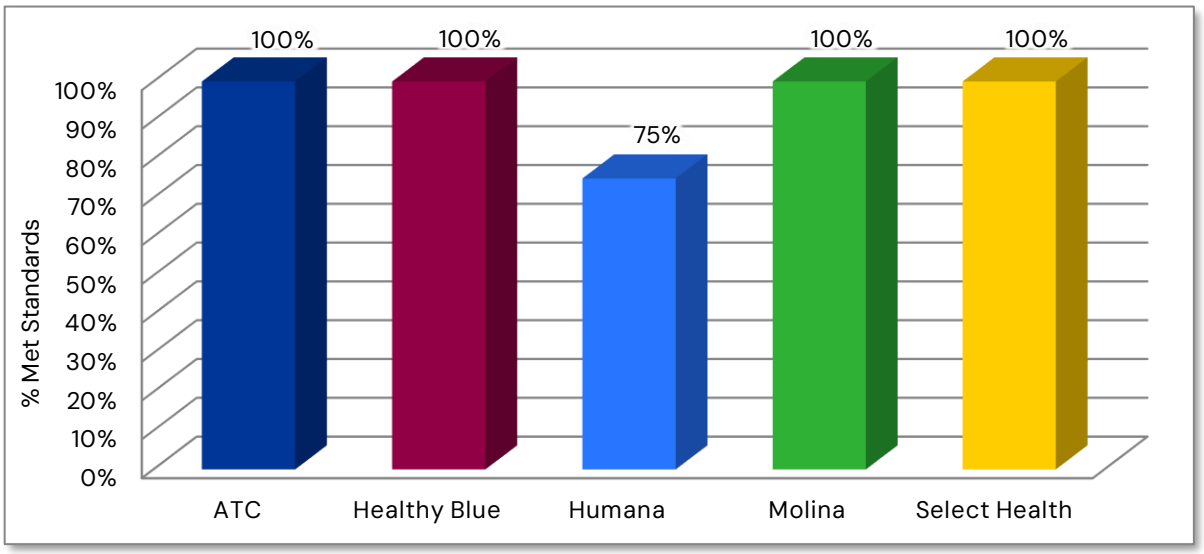
Diabetes Outcomes Measures	
The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (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 27: Select Health's 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. For this PIP, several rates are monitored. Those rates include 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 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

All the requirements were met for the MCOs except for Humana. Humana met 75% of the standards in the Quality Improvement Section as noted in *Figure 10: Quality Improvement Findings*.

Figure 10: Quality Improvement Findings



Scores were rounded to the nearest whole number.

Table 28: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The QI Programs developed by the MCOs focuses on the health care and services their members receive and includes all aspects of health care quality.	✓		
The MCOs have developed QI Work Plans that include the QI activities and objectives, timeframes for expected completion, responsible parties, and any ongoing monitoring notes.	✓		
Topics for the PIPs were selected from problems and/or needs pertinent to the member population.	✓		
The study design for QI projects met the requirements of the CMS protocol	✓		

Table 29: Quality Improvement Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
Healthy Blue's website contained information regarding the QI Program; however, this information was from 2021 and therefore, outdated.	Ensure the QI information shared with members and providers is current.	✓		
Two of the MCOs' QI work plans contained errors and/or missing information.	Errors and missing information should be corrected in the QI work plans.	✓		
Humana's QI Committee lacked a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*. This continues to be an issue for Humana.	To ensure Humana is compliant with the *SCDHHS Contract*, additional participating network providers should be recruited to serve on the QI Committee.	✓		
Humana's QI Committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings. No documentation was noted when minutes were changed or amended	For voting members absent during the committee meeting, the minutes should reflect the appointed representative. A process for how errors or changes in the committee minutes should be documented and reported to the committee.	✓		
The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation was missing data or results and contained goals that were incorrect. There were issues identified during the previous EQR and not corrected.	To assess the effectiveness of the QI Program, the results of all activities must be analyzed, barriers identified, and recommendations included in the annual QI Program Evaluation.	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
For the Immunizations for Adolescents PIP conducted by Molina, the baseline rate was 28.95% with a slight decline in the administrative rate to 28.35%. The goal is 31.19% for the annual improvement goal.	Additional locations with incentives for members may improve the rate, as well as the initiation of additional interventions to address other listed barriers.	✓		✓
For the Well Care PIP conducted by Molina, the rate showed a slight decline in the HEDIS WCV rate from 44.11% at baseline to 43.36% for remeasurement one	Continue to assess interventions to determine the impact on the final measure rate available in mid-2023.	✓		
For the Diabetes Outcomes PIP conducted by Select Health, the results showed a slight decline in the HBA1C <8% measure 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.	✓		
The Well Care Visits for Foster Care Population PIP conducted by Select Health, showed a decline in the Adolescent well care rate, the well child visit in the first 15 months, the well child visits in 3rd, 4th ,5th, and 6th years of life, the well child visits in the first 30 months of life, the well child visit for 3-11 years, the well child visit for 12- 17 years, and the total well child visit rate.	Continue interventions and assess impact of each intervention wherein possible.	✓		

QUALITY IMPROVEMENT

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*					
The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	Met	Met ↑	Met	Met
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Partially Met ↓	Met	Met
Quality Improvement Committee					
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Not Met	Met	Met
The QI Committee meets at regular quarterly intervals	Met	Met	Met	Met	Met
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Partially Met ↓	Met	Met
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*					
Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met	Met	Met	Met
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*					
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Met	Met	Met	Met	Met
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Met	Met	Met	Met
Provider Participation in Quality Improvement Activities					
The MCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The MCO tracks provider compliance with Administering required immunizations	Met	*	Met	*	Met
Performing EPSDTs/Well Child Visits	Met	*	Met	*	Met
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*					
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met	Partially Met	Met↑	Met
The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors	Met	Met	Met	Met	Met

** New Standards added after the EQR was completed.*

E. Utilization Management

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

The health plans have appropriate program descriptions, policies, and guidelines that describe how utilization management (UM) services are operationalized for physical health, behavioral health, and pharmaceutical services for members. The program's purpose, goals, objectives, and staff roles are described appropriately in the respective program descriptions and polices. Each of the health plans has a Medical Director that provides clinical oversight of the UM Program, and a Behavioral Health Medical Director and Pharmacy Director that provide oversight of their respective programs.

Coverage and Authorization of Services

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

Initial review determinations are made by licensed clinical staff that utilize approved clinical criteria. Molina's procedure incorrectly referenced the criteria utilized by reviewers when making clinical coverage determinations.

UM Program Descriptions and policies provide an overview of the timeliness requirements for processing UM decisions. However, there were inconsistencies in ATC's UM Program Description and in their policy regarding the timeframe for providers to notify the health plan of a service authorization request.

Each of the health plans provides information regarding covered prescriptions. This includes a copy of the Preferred Drug List (PDL) on their websites. The *SCDHHS Contract* requires that negative PDL changes are published on the health plans' websites at least 30 days prior to implementation. Select Health's 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.

The MCOs offer Preferred Provider Programs; however, issues were identified for ATC and Select Health. Select Health described two processes they have implemented (Contract Exceptions and Auto Assignment) for the Preferred Provider Program. Neither of these processes is communicated to the provider and they do not correspond with the described process outlined in Select Health's policy. ATC did not include the identification and tracking of preferred provider status and did not have a process for making providers aware of the program.

Constellation Quality Health's review of approval and denial files found that the files appeared to be completed in a timely manner and were processed according to requirements. However, Humana and ATC's adverse benefit determination notices incorrectly informed the member that a written appeal is required when an oral appeal request is submitted.

Appeals

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

The MCOs define and describe processes for handling member appeals in policies, Member Handbooks, Provider Manuals, and on health plan websites. A request to review an adverse benefit determination may be filed by a member, their authorized representative, or a provider on behalf of the member verbally or in writing.

Appropriate timeframes for appeal acknowledgment, resolution, and extension, if needed, are documented consistently throughout each plan's materials. Humana's policy and appeal acknowledgement letter did not address the requirement that members may file a grievance if they disagree with an extension of the appeal resolution timeframe.

Molina's UM Program Description and two letter templates referenced the requirement that a written appeal request must be submitted after a verbal request. This issue was identified during the previous EQR and not corrected.

For the random sample of appeal files reviewed for each health plan, all were processed timely and included documentation of the review by an appropriately credentialed reviewer. Healthy Blue and Select Health's appeal file review found issues with the appeal acknowledgments letters and the incorrect resolution timeframe when an extension was used.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

Each health plan has program descriptions and policies that provide a thorough overview of processes for providing care management services to members. Healthy Blue's Complex Care Management Program Description included information regarding the Clinical Advisory Group that provides oversight; however, the health plan indicated that currently, there was not a Clinical Advisory Group.

Members are referred to care management through various referral sources. Based upon completion of the Health Risk Assessment, members are provided care management activities that correspond to their risk level, and specialized programs are also offered for members with specific identified needs. Transition of care services are also provided for members.

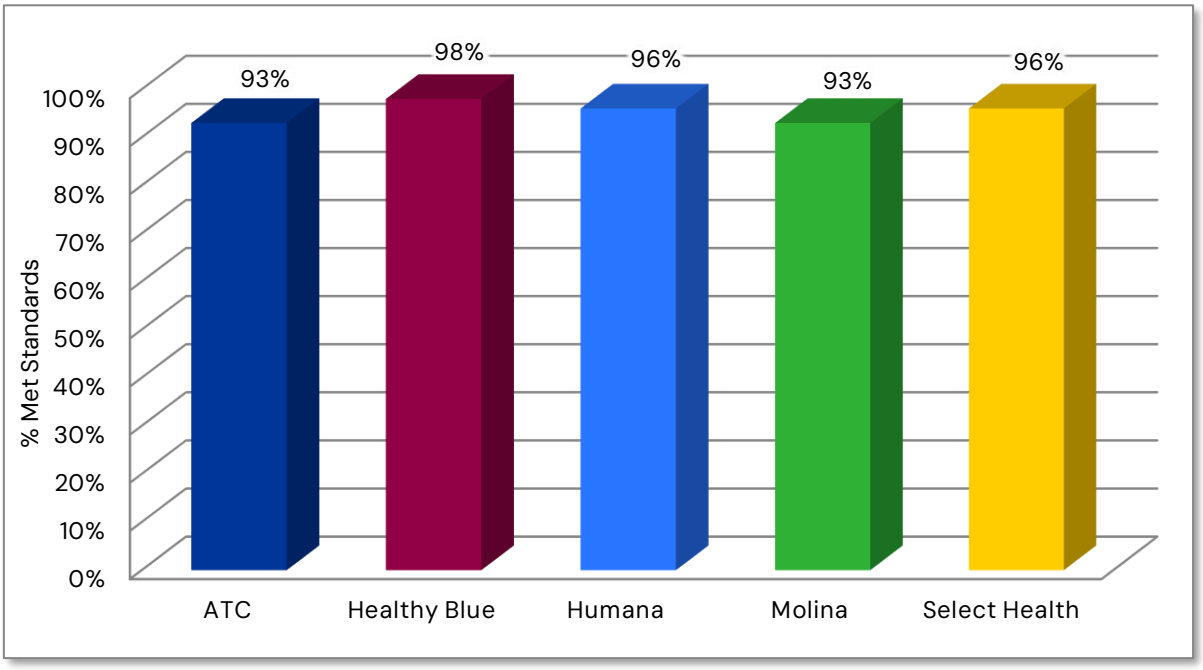
Constellation Quality Health conducted a review of care management files and found that, overall, care management activities are conducted as required, including assessments, treatment planning, follow up, and linkage to appropriate community resources. However, there were some issues identified in Molina's care management files. There were several files that did not include the date the Individualized Care Plan was created and lacked ongoing documentation of a follow up schedule for members receiving care management services.

Over and Underutilization

Monitoring over- and underutilization in Medicaid is crucial for ensuring the efficient use of resources and the provision of adequate care to beneficiaries. A review of the desk materials for the five health plans identified several methods in which over- and underutilization is monitored and assessed for clinical and behavioral outcomes. All plans showed evidence of established benchmarks for utilization rates based on evidence-based guidelines, best practices, or historical data. The methods included claims analysis, which involved analyzing claims data to reveal patterns of overutilization (excessive services rendered) or underutilization (lack of necessary services) of Medicaid benefits. The plans also conducted utilization review programs, which assess the medical necessity, appropriateness, and efficiency of healthcare services provided to Medicaid beneficiaries. Provider Performance Monitoring has been active among all plans and allows for monitoring provider performance to identify outliers who may be contributing to over- or underutilization. There are also several QI initiatives focused on enhancing care coordination, promoting evidence-based practices, and addressing disparities to optimize healthcare utilization and outcomes among Medicaid beneficiaries.

The figure and tables that follow provide a comparison of the MCO scores for the Utilization Management section as well as the strengths, weaknesses, and recommendations.

Figure 11: Utilization Management Findings



Scores were rounded to the nearest whole number.

Table 30: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Approval files were completed in a timely manner and reviewers utilized appropriate clinical criteria guidelines.		✓	✓
Denial decisions were made by an appropriate physician and the reasons for the denials were clearly documented.	✓		✓
ATC and Humana exceed the targeted monthly goal in processing service authorization requests.		✓	✓
Healthy Blue, ATC, and Humana have developed specialized programs and initiatives to increase member engagement in the care management program.			✓
All five MCOs have outlined policies and guidelines in analyzing trends and patterns for over- and underutilization.	✓		
The MCOs engage in patient education and outreach efforts to empower Medicaid beneficiaries to make informed healthcare decisions, seek appropriate care when needed, and avoid unnecessary utilization of services.	✓		✓
A review of the desk materials demonstrated collaboration and coordination among healthcare providers, managed care organizations, and other stakeholders to share data, best practices, and strategies for monitoring and addressing over- and underutilization effectively.	✓		
Of the appeal files reviewed for each MCO, all were addressed timely and were reviewed by appropriately credentialed personnel.		✓	✓

Table 31: Utilization Management Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
There was no information regarding when the negative PDL changes were published on Select Health's website.	Ensure notices of negative PDL changes are posted on the health plan's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*		✓	✓
Molina's procedure incorrectly referenced the criteria utilized by reviewers when making clinical coverage determinations.	Policies, procedures, and program descriptions should reference the criteria utilized by reviewers when making clinical coverage determinations.	✓		✓
ATC had inconsistent information in the UM Program Description and policy regarding the timeframe for providers to notify ATC of a service authorization request.	Correct the inconsistencies in program materials regarding timeframes for services authorization requests and pharmacy authorizations.		✓	✓
The Preferred Provider Programs for two health plans lacked details regarding the process for inclusion in the program,	Develop and implement a Preferred Provider Program in accordance with *SCDHHS Contract, Section 8.5.2.8* and	✓		

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
tracking the provider status, and the process for making providers aware of the program.	include the specifics for the program in respective policies.			
Member notices (Humana, ATC, and Molina) and a UM Program Description (Molina) incorrectly indicate that a written appeal is required when an oral appeal request is submitted. This issue was identified during the previous EQR for Molina and not corrected.	Remove the requirement that a written appeal must be submitted following an oral request for appeal in member notices and UM Program Descriptions.			✓
The care management files for Molina did not include the date the Individualized Care Plan was developed and did not have documentation of a follow-up schedule for members receiving case management services.	Improve the documentation in the care management files to include the date the Individualized Care Plan was developed and documentation of follow-up to assess member progress.	✓	✓	
Humana's policy and appeal acknowledgement letter did not address the requirement that members may file a grievance if they disagree with an extension of the appeal resolution timeframe.	Notify members that a grievance may be filed if they disagree with the health plan's request to extend the appeal resolution.			✓
Healthy Blue and Select Health's appeal files had issues with the appeal acknowledgements and the resolution timeframe.	Ensure that acknowledgement letters are sent when a member requests an appeal and the letter includes the correct timeframe for resolutions.		✓	✓

UTILIZATION MANAGEMENT

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
The Utilization Management (UM) Program					
The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	Met	Met	Met ↑	Met	Met
Structure of the program and methodology used to evaluate the medical necessity	Met	Met	Met	Met	Met
Lines of responsibility and accountability	Met	Met	Met	Met	Met
Guidelines / standards to be used in making utilization management decisions	Met	Met	Met ↑	Met	Met
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met ↓	Met	Met	Met	Met
Consideration of new technology	Met	Met	Met	Met	Met
The absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met
The mechanism to provide for a preferred provider program.	Partially Met ↓	Met	Met	Met	Partially Met ↓
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met
Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*					
Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Partially Met ↓	Met
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Met	Met	Met	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Met↑	Met	Met↑	Partially Met ↓
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Met	Met↑	Met	Met
Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Met
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met
Denials A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Partially Met ↓	Met	Partially Met ↓	Met	Met
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*					
The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	Met	Met	Partially Met ↓	Met	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met	Met	Met
The procedure for filing an appeal	Met	Met	Met	Partially Met	Met ↑
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Met	Met	Met	Met

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Written notice of the appeal resolution as required by the contract	Met	Met	Met	Met	Met
Other requirements as specified in the contract	Met	Met	Met	Met	Met
The MCO applies the appeal policies and procedures as formulated	Met	Partially Met	Met ↑	Met ↑	Partially Met
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*					
The MCO formulates policies and procedures that describe its care management/care coordination programs	Met	Met	Met	Met	Met
The MCO has processes to identify members who may benefit from care management	Met	Met	Met	Met	Met
The MCO provides care management activities based on the member's risk stratification	Met	Met	Met	Met	Met
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met	Met
The MCO conducts required care management activities for members receiving behavioral health services	Met	Met	Met	Met	Met
Care Transitions activities include all contractually required components The MCO has developed and implemented policies and procedures that address transition of care	Met	Met	Met	Met	Met
The MCO has a designated Transition Coordinator who meets contract requirements	Met	Met	Met	Met	Met
The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary	Met	Met	Met	Met	Met
Care management and coordination activities are conducted as required	Met	Met	Met	Partially Met	Met
Evaluation of Over/ Underutilization					
The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract	Met	Met	Met	Met	Met
The MCO monitors and analyzes utilization data for over- and under-utilization.	Met	Met	Met	Met	Met

F. Delegation

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

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

ATC reported delegation agreements with 23 entities listed in *Table 32: Delegated Entities and Services – ATC*.

Table 32: Delegated Entities and Services – ATC

Delegated Entities	Delegated Services
• CareCentrix	• Case Management • Claims/Payments • Credentialing - Facilities • Network Management • Utilization Management
• CVS	• Pharmacy Standards (Claims, Credentialing, Network Management)
• Envolve Vision	• Claims/Payments • Provider Payment Appeals • Credentialing - Practitioners • Utilization Management
• Express Scripts	• Medication Therapy Management • Pharmacy Services - Claims, Credentialing, Network Management
• Medical Review Institute of America	• Utilization Management • Utilization Management - Member Appeals
• ModivCare	• Transportation Standards
• National Imaging Associates	• Customer Service • Utilization Management • Utilization Management - Member Appeals
• New Century Health	Utilization Management
• TurningPoint Healthcare Solutions	• Customer Service • Utilization Management • Utilization Management - Member Appeals
• AU Medical Center • Bon Secours St. Frances Physician Services • United Physicians • Preferred Care of Aiken • CVS Health Minute Clinic • Self Regional Health Care • Prisma Palmetto USC • AnMed Health	• Credentialing and recredentialing

Delegated Entities	Delegated Services
• Lexington Medical Center • Regional Health Plus Spartanburg • Roper St. Francis Physicians Network • Health Network Solutions • Management and Network Services, LLC • Medical University of South Carolina	

Healthy Blue reported delegation agreements with 12 entities listed in *Table 33: Delegated Entities and Services – Healthy Blue*.

Table 33: Delegated Entities and Services – Healthy Blue

Delegated Entities	Delegated Services
• CarelonRx • CaremarkPCS (CVS)	• Pharmacy benefit management
• AnMed Health • HCA Physicians Services Group • Medical University of South Carolina • Prisma Health • Roper St. Francis Physician's Network • Self Regional Healthcare • South Carolina Department of Mental Health • Spartanburg Health/Regional Health Plus • Tenet (HCS Physicians) • VSP Vision Care	• Credentialing

Humana reported delegation agreements with 14 entities, as shown in *Table 34: Delegated Entities and Services – Humana*.

Table 34: Delegated Entities and Services – Humana

Delegated Entities	Delegated Services
• ANMED Health	• Credentialing
• Block Vision, dba Superior Vision Benefit Management	• Vision Network Management, Claims Processing, Credentialing
• Censeo Health, dba Signify Health	• Credentialing, Health Risk Assessments
• Focus Health, dba Focus Behavioral Health	• Behavioral Health Utilization Management, Appeals
• Modivcare Solutions	• Non-emergent transportation services, Claims Processing

Delegated Entities	Delegated Services
• Network Medical Review Company	• Utilization Management, Appeals
• Hanger Prosthetics & Orthotics • HCN Physicians and the subsidiaries of Tenet Healthcare • Medical University Hospital Authority/MUSC Medical Center • Prisma Health • Self Regional Healthcare • South Carolina Department of Mental Health • St. Francis Physician Services • United Physicians	• Credentialing

Molina reported 14 delegation agreements, as shown in *Table 35: Delegated Entities and Services – Molina*.

Table 35: Delegated Entities and Services – Molina

Delegated Entities	Delegated Services
• Accordant Care Rare (CVS)	• Case Management
• Aperture	• Credentialing Verification
• March Vision Care	• Credentialing, Claims, Call Center
• AnMed Health • Regional Health Partners • Medical University of South Carolina • Prisma Midlands • Prisma Upstate • Augusta University Medical Center • Managed Health Resources • Bon Secours St. Francis • Roper St. Francis • Lexington Medical Center • Tenet Physicians	• Credentialing

Select Health reported 15 delegation agreements, as shown in *Table 36: Delegated Entities and Services – Select Health*.

Table 36: Delegated Entities and Services – Select Health

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

Health plan policies address processes that must be followed to delegate health plan functions to other entities. These processes include:

- Conducting pre-delegation evaluations to determine potential delegates' abilities to comply with contractual requirements and health plan standards.
- Implementing written agreements that specify the delegated activities and functions, delegate responsibilities, reporting requirements, additional terms and conditions, consequences of noncompliant or substandard performance, etc. with each approved delegate.
- Conducting annual oversight and ongoing monitoring of approved delegates.

Constellation Quality Health reviewed the delegate oversight documentation provided by each of the MCOs. No issues were identified for Healthy Blue, Molina, and Select Health. For ATC and Humana, identified deficiencies included:

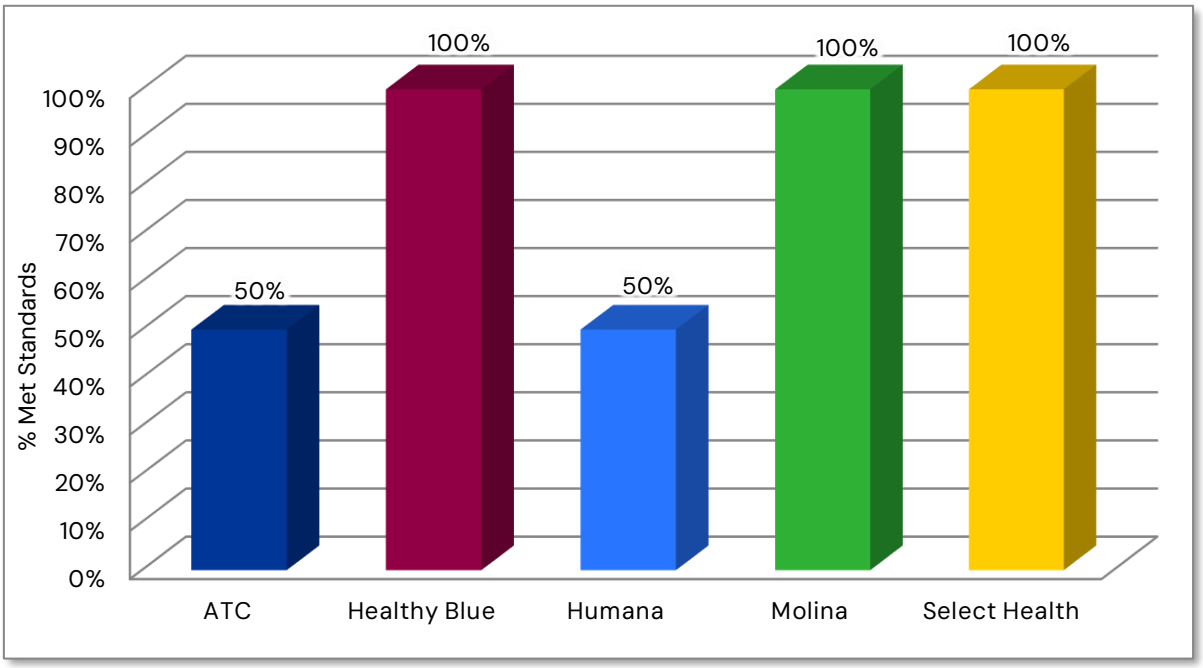
- ATC's Oversight of Delegated Credentialing policy (CC.CRED.12) states summaries of annual delegation oversight are reported to the Credentialing and/or Quality Improvement Committee for review and approval. For the previous EQR, ATC staff reported that the credentialing oversight information is reported to the Credentialing Committee and oversight for other entities is reported to the Quality Improvement Committee (QIC). For the most recent EQR, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of

credentialing delegation oversight. Therefore, this was an uncorrected deficiency from the previous EQR.

- Humana's Delegation Policy (SC.DCO.001) did not include the requirement to notify SCDHHS of any further delegation by a subcontractor, as required by the *SCDHHS Contract, Section 2.5.11*.
- Humana's delegation oversight audit tools reflected audit staff incorrectly indicated the elements regarding CLIA verification and collection of nurse practitioner collaborative agreements were not applicable for some delegates. Also, hospital admitting privileges were not consistently checked during the file review.

As noted in *Figure 12: Delegation Findings*, three of the MCOs achieved "Met" scores for 100% of the Delegation standards. Two health plans, ATC and Humana, achieved "Met scores for 50% of the Delegation standards.

Figure 12: Delegation Findings



Scores were rounded to the nearest whole number.

Strengths, weaknesses, and recommendations are detailed in *Table 37: Delegation Strengths* and *Table 38: Delegation Weaknesses and Recommendations*.

Table 37: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Processes for pre-delegation assessments, approval of delegation, annual delegation oversight, and ongoing monitoring are thoroughly documented in policies.	✓		
No issues were identified for Healthy Blue, Molina, and Select Health when reviewing the delegate oversight documentation provided by each of the MCOs.	✓		

Table 38: Delegation Weaknesses, and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
The review of delegate oversight documentation provided by each of the MCOs revealed issues related to: • Noncompliance with health plan policy to report credentialing delegation oversight summaries to the Credentialing Committee (ATC). This was an uncorrected deficiency from the previous EQR. • Failure to include in applicable policy the requirement to notify SCDHHS of any further delegation by a subcontractor (Humana). • Incorrect indications of "not applicable" on credentialing delegation oversight audit tools for CLIA verification and collection of nurse practitioner collaborative agreements (Humana). • Failure to consistently monitor credentialing delegates for checking hospital admitting privileges during file review (Humana).	Ensure delegation oversight activities incorporate all contractual and policy requirements, and that delegation oversight reporting is consistent with policy requirements.	✓		

DELEGATION

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*					
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Met	Met
The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Partially Met	Met↑	Partially Met ↓	Met	Met

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 is required to conduct a Mental Health Parity assessment to determine if the MCOs met the Mental Health Parity requirements outlined in the *Federal Parity Act*. This assessment is conducted as a two-step process. Step one involves 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 assesses the non-quantitative treatment limitations (NQTLs), such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limitations on the scope or duration of benefits. The Mental Health Parity assessment was conducted for ATC, Humana, and Select Health. The Mental Health Parity assessment for Healthy Blue and Molina will be conducted in the 2024 EQRs.

The MCOs provided Program Descriptions, various utilization and network access reports, Member and Provider Handbooks, benefit maps, NQTL lists and comparison charts, and QTL lists 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 Non-Quantitative Treatment Limitations (NQTL) Assessment

Constellation Quality Health reviewed supporting documentation 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 – Humana uses MCG as their medical and behavioral health criteria. Select Health uses InterQual. Both health plans use ASAM for substance use disorders.

Clinical Auditing - IRR is conducted by both health plans' corporate teams, which select case studies from each benefit category.

Utilization Management (UM) Reviews: - Humana has delegated their mental health adverse determinations and appeals to FOCUS. Monthly Joint Operational Committee meetings have been established for vendor oversight. They continue to work to improve communications and streamline handoff processes, which are complicated by system incompatibility between Humana and FOCUS.

Appeals and Denials – Humana's medical necessity denial rates for medical/surgical and behavioral health/substance use are comparable. Administrative denials are not being used currently, as Humana is still building their provider network. 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.

Provider Network – As a new health plan, Humana is still building their provider network. At this time, Humana's policy is to not deny administratively based upon contracted status. Humana has launched a Network Adequacy Workgroup to address gaps in access to care, reflected in the low Experience of Care and Health Outcomes (ECHO) Survey results for the "Getting Treatment Quickly" composite. Select Health's Behavioral Health network is robust. Any gaps are in rural areas where demand for services exceeds available practitioners.

Humana and Select Health have 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.

ATC provided their Medical Program Descriptions, various utilization and network access reports, Member and Provider Handbooks. The corresponding documents for MH/SUD were not provided. Therefore, Constellation Quality Health was unable to complete the Parity Assessment.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to the MCOs to complete the mental health parity assessment. The templates allow the plans to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and QTLs that apply to MH/SUD benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. ATC did not complete the templates. Therefore, Constellation Quality Health was unable to complete the assessment.

There are two steps required to conduct this review. First, Constellation Quality Health determined if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject.

The files submitted by Humana demonstrated a copay for prescriptions and no limits or copays for inpatient or outpatient services. The $3.40 copay applied to prescriptions is consistent for medical/surgical and behavioral health services. Thus, the findings show appropriate parity for mental health services in relation to medical services.

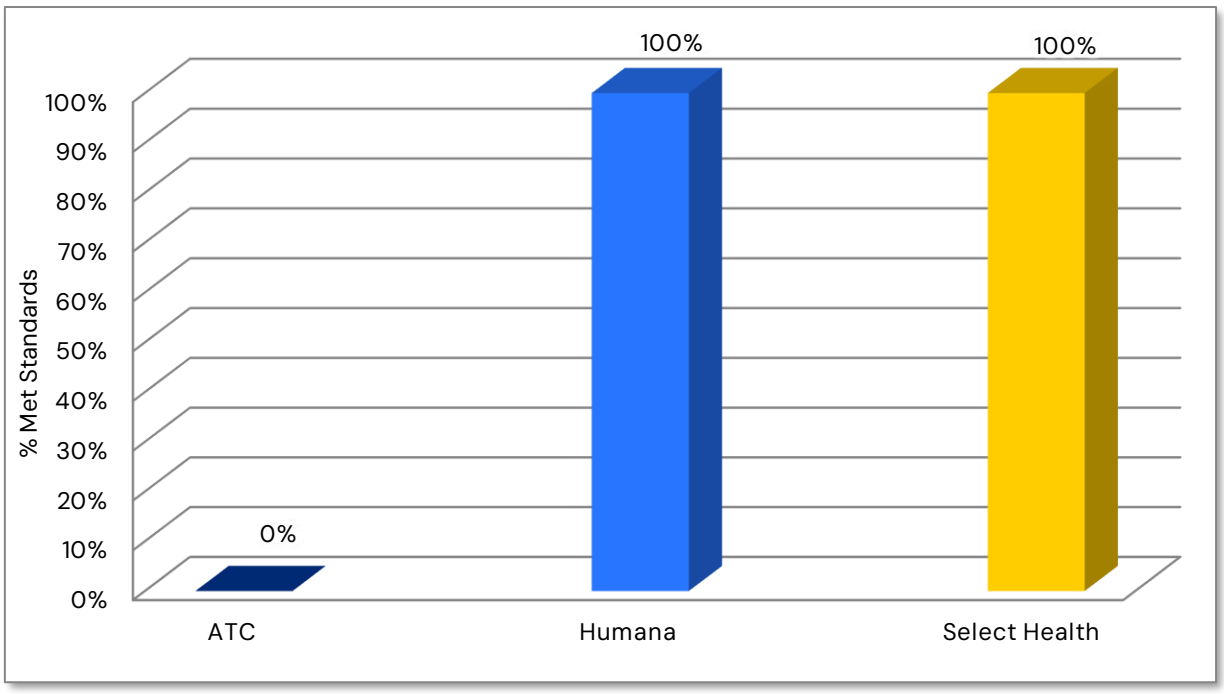
Select Health reported a copay for inpatient, outpatient, and pharmacy services ($3.30), which was consistent for medical/surgical and behavioral health services. Additionally, the inpatient

mental health copay does not exceed $25.00, which is consistent with the medical/surgical requirement. Emergency services do not have any financial requirements.

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

Figure 13: Mental Health Parity Findings indicates Humana and Select Health met the requirements for the Mental Health Parity assessment. ATC did not provide all the information needed to conduct the assessment.

Figure 13: Mental Health Parity Findings



Scores were rounded to the nearest whole number.

Constellation Quality Health conducted a teleconference with ATC following the onsite to discuss the documentation needed to complete the assessment. ATC submitted the requested documentation, and the Mental Health Parity assessment was conducted. Constellation completed the assessment and found that ATC was compliant with the NQTLs and QTLs and met the Mental Health Parity requirements.

Table 39: Mental Health Parity Strengths and Table 40: Mental Health Parity Weaknesses and Recommendations notes the strengths, weaknesses, and recommendations for the Mental Health Parity assessments.

Table 39: Mental Health Parity Strengths

Strengths	Quality	Timeliness	Access to Care
The 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.			✓
Inter-Rater Reliability incorporates both mental health and substance use disorder and medical/surgical cases.	✓		

Table 40: Mental Health Parity Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
ATC provided insufficient documentation to conduct the assessment of Mental Health Parity.	To determine compliance with the Mental Health Parity and Addiction Equity Act, ATC must complete the Mental Health Parity templates and reports and submit these documents to Constellation Quality Health for review.	✓		
Humana's provider Network is not robust in certain regions; this is reflected in low scores for getting mental health services quickly on the ECHO survey.	Continue to convene the Network Adequacy Workgroup. Continue the policy of not denying care based on the provider's contracted status.			✓
Integration issues with FOCUS, Humana's Behavioral Health vendor who performs reviews when associates are unable to approve a request could result in timeliness or access to care issues.	Continue with training and staff support as well as JOC meetings.			✓
Select Health's 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 medical/surgical. 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.	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.			✓

MENTAL HEALTH PARITY

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Mental Health Parity					
The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations	Not Met	*	Met	*	Met
The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	Not Met	*	Met	*	Met

** New Standards added after the EQR was completed.*

SC Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. Constellation Quality Health's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement (QI) and Care Coordination/Case Management Programs.

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

A. Administration

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

The Administration section covers policies and procedures, the organizational structure and staffing, the governing board, contract requirements, confidentiality, and compliance and program integrity.

Policies are managed in accordance with Policy CHS.ADM.ALL.01.01, Policy and Procedure Management. A master list of all policies and procedures is maintained by the Compliance Department, which facilitates the annual policy review process. During the onsite, Solutions provided a copy of Policy CHS.ADM.MCCW.01.03, Employment of Family Member of MCCW Participant, which is a new policy that provides guidelines for Solutions' employees who have a family member eligible for the Medically Complex Children's Waiver (MCCW). At the time of the review, this policy was not yet approved by the State.

Solutions' Organizational Chart indicates that one physician staff member serves as Executive Director and Medical Director, responsible for the day-to-day activities. An additional physician is contracted as the Medical Advisor to provide clinical consultation to Care Coordinators for medically complex cases and attend meetings as assigned by the Medical Director. Three full-time Directors of Care Coordination oversee the Care Coordinators located in the Midlands, Upstate, and Low Country regions. There was one vacant position noted for both the Midlands and the Upstate regions on the organizational chart. During the onsite, it was shared that vacant positions for each region had been filled. When Care Coordinators are on paid time off or caseloads are high, explanations for coverage were provided. At the time of the 2023 EQR, the position of Chief Technology Officer was filled on an interim basis.

The personnel sample file review found that monthly exclusion screenings were present for most files. Evidence of the required auto insurance, driver's license, drug screening, and background checks was found. One file contained an undated job description; however, Solutions provided the dated job description post-onsite.

The Solutions website and Provider Manual noted the hours of operation as 8:00 a.m. to 5:00 p.m. The member's PCP serves as the first point of contact, and 911 is recommended for after-hours member emergencies.

Confidentiality training for staff is conducted at the time of employment and annually thereafter. Information technology-related positions and management-level positions require an additional Confidentiality and Invention Assignment Agreement as a condition of employment.

The 2023 Compliance Program document clearly defines FWA. Employees and members are informed of their right and responsibility to report actual or suspected FWA through the Employee Handbook and in the member's Report Medicaid Fraud, Waste, and Abuse flyer. The Compliance Program document describes the process for Solutions' oversight of the compliance policy and the corrective actions taken to address and prevent future occurrences of misconduct or non-compliance. Policy CHS.CM.MCCW.01.11k, Reporting Fraud, Waste, and Abuse, provides phone, email, or mailing options for reporting FWA to SCDHHS.

Information Systems Capabilities

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

Solutions has policies and processes in place for addressing data, systems, information security and access management. These policies comply with SCDHHS' requirements for managing Protected Health Information. The policies included a history of reviews and changes indicating regular review occurs.

Solutions conducted a tabletop disaster recovery exercise in May 2023. This exercise identified that redundancies are in place to minimize a possible outage, with one exception related to a router that was found to not be configured in a redundant manner. Documentation indicated that efforts were in place to correct this issue. Solutions provided the standard operating procedure and indicated a new infrastructure was purchased to automatically handle circuit failover. Failover testing procedures are in place with a test planned for October 2023.

All of the standards for the Administration section were scored as "Met," as noted in *Table 41: Solutions Administration Findings*.

Table 41: Solutions Administration Findings

Standard	Score
General Approach to Policies and Procedures	
Policies and procedures are organized, reviewed, and available to staff	Met
Organizational Chart / Staffing	
The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities: Administrative oversight of day-to-day activities of the organization	Met
Pre-assessment	Met
Care coordination and enhanced case management	Met
Provider services and education	Met
Quality assurance	Met
Designated compliance officer	Met
The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, the following are included: Criminal background checks are conducted on all potential employees	Met
Verification of nursing licensure and license status	Met
Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs	Met
Ensuring Care Coordinators and Pre-Admission Screening staff meet all contract requirements	Met
Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a participant's Person-Centered Service Plan	Met
Employee personnel files demonstrate compliance with contract and policy requirements	Met ↑
Governing Board/Advisory Board	
The Organization has established a governing body or Advisory Board	Met
The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined	Met
Contract Requirements	
The organization carries out all activities and responsibilities required by the contract, including but not limited to: Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday	Met
Adherence to contract requirements for holidays and closed days	Met
Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS	Met

Standard	Score
Organization and participant record retention and availability as required by the contract	Met
Participant materials written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages	Met
Processes are in place to ensure care coordination services are available statewide	Met
Confidentiality	
The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy	Met
Data Systems/Security	
Policies, procedures and/or processes are in place for addressing data, system, and information security and access management	Met
The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented	Met
Compliance and Program Integrity	
The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following: Written policies, procedures, and standards of conduct comply with federal and state standards and regulations	Met
A compliance committee that is accountable to senior management	Met
Employee education and training that includes education on the False Claims Act, if applicable	Met
Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers	Met
Enforcement of standards through well-publicized disciplinary guidelines	Met
Provisions for internal monitoring and auditing	Met
Provisions for prompt response to detected offenses and development of corrective action initiatives	Met
A system for training and education for the Compliance Officer, senior management, and employees	Met
Processes for immediate reporting of any suspicion or knowledge of fraud and abuse	Met
The organization reports immediately any suspicion or knowledge of fraud or abuse	Met

B. Provider Services

The review of Provider Services includes initial provider orientation and ongoing education policies and processes. Solutions addresses initial and ongoing provider education processes and topics in policy. Initial provider orientation is conducted within 30 days of contracting by the Director of Network Programs through face-to-face or virtual sessions. At the time of the provider's

recredentialing, routine provider education is conducted every three years. Additional provider updates are provided at least annually. The review found that Solutions' policy incorrectly stated the frequency of ongoing provider education. Solutions uses the Medically Complex Children Waiver Enhanced Provider Network Orientation document for initial provider education.

The Provider Manual is an additional resource for information providers need to operate within Solutions' network. Also, Solutions' website provides brief information about the MCCW program, billing, reimbursement, use of Medicaid guidelines, and the SCDHHS Preferred Drug List, etc. The website provides links to SCDHHS, the SCDHHS Provider Manuals, and forums to report FWA.

Solutions received scores of "Met" for all standards in the Provider Services section, as noted in *Table 42: Provider Services Findings*.

Table 42: Provider Services Findings

Standard	Score
Provider Services	
The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Met
Initial provider education includes: Organization structure, operations, and goals	Met
Medical record documentation requirements, handling, availability, retention, and confidentiality	Met
How to access language interpretation services	Met
The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Met

C. Quality Improvement

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

Solutions' Quality Improvement (QI) Program is described in the 2023 Strategic Quality Plan, which contains the program's goals, objectives, structure, scope, and processes. Solutions' Chief Medical Officer maintains primary responsibility and oversight of the QI Program. Dr. William Kent Jones, a pediatrician specializing in treating medically complex children, serves as the Medical Advisor for the program.

The QI Program Description and Policy CHS.QM.ALL.01.07, Quality Improvement Project, describes the process Solutions uses to identify opportunities for improvement and implement QI projects. Solutions has two QI projects underway for the Annual Visit and Initial Monthly Summary Reports and the Enhanced Provider Network Programs Modifications. The Annual Visit and Initial Monthly Summary Reports project appeared to contain several measures or indicators. However, during the onsite discussion, Solutions noted that this project had one measure with multiple subset measures, each of which did not have a specific goal.

The Compliance and Quality Management Committee has been established to provide oversight of Solutions' programs, including the QI activities. Membership includes directors and managers from all departments and functional areas. Meetings are held at least quarterly, and a quorum is defined as at least 50% of voting members. Non-voting members participate in the meetings but are not allowed to vote. Minutes documenting the committee's discussions, recommendations, and any follow-up, are recorded for each meeting.

Solutions conducts a formal evaluation of the QI Program annually to identify program outcomes and accomplishments. Solutions provided the 2022 Quality and Performance Annual Report. This evaluation was presented to the Compliance and Quality Management Committee and the Board of Directors for approval.

Table 43: Quality Improvement Standards and Findings provides an overview of the EQR results for solutions. Strengths and weaknesses follow.

Table 43: Quality Improvement Standards and Findings

Standard	Score
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*	
The organization 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 participants	Met
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Met
Quality Improvement Committee	
The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met
The QI Committee meets at regular intervals	Met
Minutes are maintained that document proceedings of the QI Committee	Met
Annual Evaluation of the Quality Improvement Program	
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met
The annual report of the QI program is submitted to the QI Committee	Met

D. Care Coordination/Case Management

42 CFR § 208

The structure, objectives, and processes for conducting care coordination/case management activities are outlined in the South Carolina Solutions Medically Complex Children Waiver Program Description and policies. Clinical decision-making activities and oversight of daily program operations are the responsibilities of the Chief Medical Officer, who also serves as the Executive Director. The Medical Advisor provides clinical consultation for staff when there are medical

management and/or quality of care concerns, psychosocial issues, and for complex service plan development.

Participants are provided with contractually required written materials along with information about local and state-wide resources, appeals and grievances, etc. Solutions' participant materials are available in English and Spanish. However, there are a few participant materials that are available only in English, and translators are available to provide translation services.

The COVID-19 Public Health Emergency restrictions have been lifted. Care Coordination staff have resumed in-home visits and are reassessing participants who were found to be ineligible for enrollment in the Medically Complex Children Waiver Program during the Public Health Emergency. Upon reassessment, those who do not meet eligibility requirements are disenrolled from the program, as outlined in policy. However, the Disenrollment Notification Letter appeared to be outdated.

The previous EQR revealed Solutions did not have a policy addressing discharge planning for participants who are admitted to a hospital. It also revealed that no policy provided detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant or actions taken after filing a report. This finding was appropriately addressed. Policy CHS.CM.MCCW.03.02, Discharge Planning for Hospitalized Enrolled Participants, was developed and included the process for discharge planning for participants who are admitted to an inpatient hospital. The policy also provides detailed information about Care Coordinator roles and responsibilities in the discharge planning process. Policy CHS.CM.MCCW.01.12, Child and Adult Protective Services, was revised to include details about reporting procedures and follow-up activities when it is necessary to report suspected abuse, neglect, or exploitation of a participant.

A sample of participant files was reviewed, and no issues were noted. Monthly, quarterly, semi-annual, and annual contacts were documented, and resumption of in-home visits was noted. The files reflected documentation of reassessments and updates to meet the changing needs of participants.

Of note, the QI Program Evaluation indicates Solutions staff enter any complaints received into Phoenix, and SCDHHS notifies Solutions of any complaints received about staff. In 2022, Solutions received no notifications of complaints from SCDHHS.

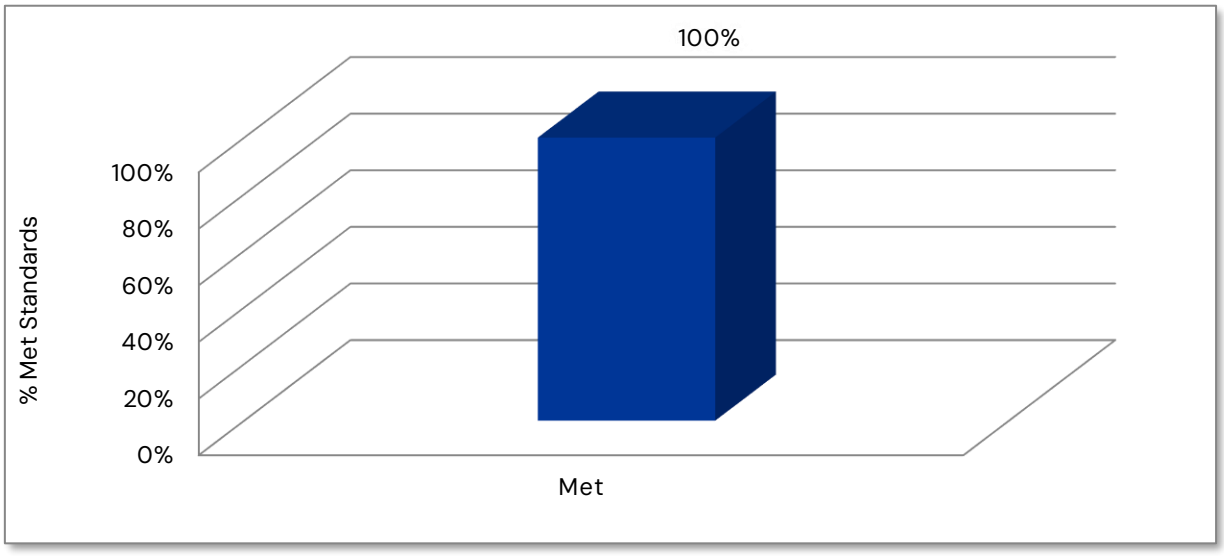
Solutions received scores of "Met" for all standards in the Care Coordination/Case Management section of the review, as noted in the table that follows.

Table 44: Care Coordination/Case Management Findings

Standard	Score
Care Coordination/Case Management *42 CFR § 208*	
The organization formulates written policies and procedures and/or a program description that describe its care coordination and case management programs	Met
Policies and procedures and/or the program description address the following: Structure of the program	Met
Lines of responsibility and accountability	Met
Goals and objectives of Care Coordination/Case Management	Met
Intake and assessment processes for Care Coordination/Case Management	Met
Providing required information to participants at the time of enrollment	Met
Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable	Met
Processes to develop, implement, coordinate, monitor, and update individual Person-Centered Service Plans	Met
Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plan	Met
Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Met ↑
Processes for reporting suspected abuse, neglect, or exploitation of a participant	Met ↑
A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Met
The organization provides a written, formal evaluation of the Person Centered Plan to SCDHHS every 6 months or upon request	Met
The organization conducts Care Coordination and Case Management functions as required by the contract	Met

Solutions met all the requirements for this EQR as noted in *Figure 14: SC Solutions Overall Findings*.

Figure 14: SC Solutions Overall Findings



Scores were rounded to the nearest whole number.

Solutions' specific strengths, weaknesses, and recommendations are displayed in T*ables 45* and *46*.

Table 45: Solutions' Strengths

Strengths	Quality	Timeliness	Access to Care
Administration			
Solutions' policies and procedures reflect an annual review cycle.		✓	
The 2023 Compliance Program document defines FWA and ensures that employees and members are informed of their right and responsibility to report instances actual or suspected FWA.	✓		
Solutions provided information systems and policy documentation that complies with the State's requirements for managing Protected Health Information.	✓		
Provider Services			
Various forums are used to conduct initial provider orientation and ongoing education, including face-to-face and virtual sessions, and virtual sessions may also be recorded for providers who are unable to attend.	✓		
The Solutions Provider Manual and website are resources for information providers need to operate effectively in Solutions' network.	✓		
Quality Improvement			
Solutions has a Strategic Quality Plan that outlines their efforts to improve the quality of care and services they provide to members.	✓		
The Compliance and Quality Management Committee has been established to provide oversight of Solutions' programs including the QI activities.	✓		
Care Coordination/Case Management			
The sample of participant care coordination files reflected care coordination/case management functions are conducted as required and confirmed that staff have resumed in-person visits. In addition, the files showed that staff work with external entities to ensure participants have necessary equipment, supplies, medications, etc.	✓		

Table 46: Solutions' Weaknesses and Recommendations

Weakness	Recommendation	Quality	Timeliness	Access to Care
Administration				
Solutions' Provider Orientation – Training policy incorrectly states the frequency of provider education.	Recommendation: Ensure policies accurately reflect frequency of provider education activities.		✓	
Quality Improvement				
The measures included in the Annual Visit and Initial Monthly Summary Reports project document were not clearly labeled	Update the Annual Visit and Initial Monthly Summary Reports project document to clearly label each measure or subset	✓		

Weakness	Recommendation	Quality	Timeliness	Access to Care
and the goals for each measure were not noted.	measure. Ensure a goal is documented for each measure or subset measure.			
Care Coordination/Case Management				
Most of the member materials provided for review included both English and Spanish versions. Solutions staff reported that when documents are available only in English, translators are available to provide translation services.	Check frequently for updates to member materials, such as alternate languages or updated versions, to ensure members receive the most current information.			✓
Policy CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment, describes processes followed when participants no longer qualify for the MCCW due to Level of Care assessments or Medical Eligibility Assessment scores. The review revealed that the Disenrollment Notification Letter appeared to be outdated (September 11, 2019).	Check with SCDHHS for current Disenrollment Notification Letter.	✓		

Coordinated and Integrated Care Organizations Annual Review

Constellation Quality Health conducted an EQR of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those plans include ATC, Molina, and Select Health. This review focused on network adequacy for home and community-based services (HCBS), behavioral health providers, over- and underutilization, and care transitions.

For the EQR activities, Constellation Quality Health used a process based on the CMS *Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations*. To conduct the review, Constellation Quality Health requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over- and underutilization data, and care transition files.

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

A. Provider Network Adequacy

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

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

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

Constellation Quality Health requested a complete list of all contracted HCBS providers currently in each health plan's network. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services.

For Molina, all 46 counties in SC had at least one member in the MMP Member Demographics 2022 file received with the desk materials. Of the 322 services across 46 counties, there were 41 services that did not meet the requirements and 281 that met the minimum requirements. This yielded a validation score of 87% (281/322). Only five counties met the minimum requirements for case management services.

Select Health had services documented for providers in 42 counties. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. Of the 294 services across 42 counties, 294 met the minimum requirements, resulting in a validation score of 100%, which was also last year's rate.

Last year, Wellcare's HCBS adequacy rate was 100%. The HCBS adequacy rate for this year was calculated as 99.7% (321 service minimums out of 322 services were met). Aiken county only has one unique Adult Day Health provider contracted.

Table 47: HCBS Provider Adequacy Results provides an overview of the network adequacy results for each CICO.

Table 47: HCBS Provider Adequacy Results

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Abbeville				
Adult Day Health	2	3	2	4
Case Management	2	0	15	3
Home Delivered Meals	2	6	5	4
PERS	2	20	17	16
Personal Care	2	44	41	22
Respite	2	13	10	8
Telemonitoring	2	3	3	3
Aiken				
Adult Day Health	2	7	5	1
Case Management	2	1	12	6
Home Delivered Meals	2	4	5	3
PERS	2	17	15	16
Personal Care	2	57	46	18
Respite	2	17	13	5
Telemonitoring	2	3	3	2
Allendale				
Adult Day Health	2	7	4	2
Case Management	2	0	12	5
Home Delivered Meals	2	3	4	2
PERS	2	17	15	15
Personal Care	2	43	38	14
Respite	2	12	11	5
Telemonitoring	2	4	4	3
Anderson				
Adult Day Health	3	9	7	4
Case Management	3	0	11	3
Home Delivered Meals	3	6	6	3
PERS	3	22	19	17
Personal Care	3	68	68	15
Respite	3	18	15	5
Telemonitoring	3	4	5	4
Bamberg				
Adult Day Health	2	9	6	4
Case Management	2	0	13	5

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Home Delivered Meals	2	4	5	3
PERS	2	17	16	17
Personal Care	2	48	42	17
Respite	2	13	11	5
Telemonitoring	2	4	4	4
Barnwell				
Adult Day Health	2	6	3	4
Case Management	2	0	11	5
Home Delivered Meals	2	3	4	4
PERS	2	17	16	17
Personal Care	2	46	40	16
Respite	2	15	11	5
Telemonitoring	2	4	4	4
Beaufort				
Adult Day Health	2	5	3	3
Case Management	2	0	11	4
Home Delivered Meals	2	3	4	3
PERS	2	17	15	16
Personal Care	2	45	35	14
Respite	2	17	13	5
Telemonitoring	2	3	3	4
Berkeley				
Adult Day Health	2	8	7	4
Case Management	2	0	12	6
Home Delivered Meals	2	4	5	3
PERS	2	18	15	16
Personal Care	2	48	44	17
Respite	2	16	15	7
Telemonitoring	2	4	5	4
Calhoun				
Adult Day Health	2	11	13	5
Case Management	2	0	12	4
Home Delivered Meals	2	3	5	4
PERS	2	18	16	17
Personal Care	2	50	46	17
Respite	2	14	13	4
Telemonitoring	2	4	4	4

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Charleston				
Adult Day Health	3	9	8	6
Case Management	3	0	12	6
Home Delivered Meals	3	5	6	4
PERS	3	18	15	16
Personal Care	3	57	48	20
Respite	3	16	15	8
Telemonitoring	3	4	5	4
Cherokee				
Adult Day Health	2	3	5	3
Case Management	2	0	9	4
Home Delivered Meals	2	4	4	2
PERS	2	18	17	16
Personal Care	2	43	43	16
Respite	2	14	12	6
Telemonitoring	2	5	5	4
Chester				
Adult Day Health	2	8	8	6
Case Management	2	0	10	3
Home Delivered Meals	2	3	4	3
PERS	2	17	16	16
Personal Care	2	46	48	23
Respite	2	17	16	10
Telemonitoring	2	3	3	3
Chesterfield				
Adult Day Health	2	4	5	2
Case Management	2	2	11	3
Home Delivered Meals	2	4	5	5
PERS	2	18	15	16
Personal Care	2	43	43	16
Respite	2	16	16	6
Telemonitoring	2	3	3	3
Clarendon				
Adult Day Health	2	6	5	4
Case Management	2	1	15	6
Home Delivered Meals	2	4	6	3
PERS	2	19	15	17

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Personal Care	2	56	54	18
Respite	2	19	15	6
Telemonitoring	2	3	3	3
Colleton				
Adult Day Health	2	8	6	5
Case Management	2	0	11	5
Home Delivered Meals	2	4	5	4
PERS	2	18	13	16
Personal Care	2	43	35	17
Respite	2	15	12	7
Telemonitoring	2	4	4	4
Darlington				
Adult Day Health	2	3	N/A	2
Case Management	2	2		5
Home Delivered Meals	2	3		2
PERS	2	19		16
Personal Care	2	58		19
Respite	2	15		6
Telemonitoring	2	3		2
Dillon				
Adult Day Health	2	3	5	2
Case Management	2	2	12	4
Home Delivered Meals	2	4	5	3
PERS	2	19	1	19
Personal Care	2	50	48	15
Respite	2	15	14	5
Telemonitoring	2	3	3	3
Dorchester				
Adult Day Health	2	9	8	3
Case Management	2	0	12	5
Home Delivered Meals	2	4	5	2
PERS	2	18	15	15
Personal Care	2	48	43	18
Respite	2	15	14	8
Telemonitoring	2	4	5	3
Edgefield				
Adult Day Health	2	3	3	3

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Case Management	2	1	14	3
Home Delivered Meals	2	4	5	3
PERS	2	18	16	16
Personal Care	2	41	41	14
Respite	2	14	11	6
Telemonitoring	2	3	3	2
Fairfield				
Adult Day Health	2	8	11	5
Case Management	2	1	14	4
Home Delivered Meals	2	4	5	4
PERS	2	17	16	17
Personal Care	2	63	54	25
Respite	2	18	14	9
Telemonitoring	2	3	3	3
Florence				
Adult Day Health	3	4	7	3
Case Management	3	2	15	5
Home Delivered Meals	3	4	5	4
PERS	3	19	13	19
Personal Care	3	64	59	22
Respite	3	16	16	6
Telemonitoring	3	3	3	3
Georgetown				
Adult Day Health	2	6	7	4
Case Management	2	1	12	6
Home Delivered Meals	2	3	4	3
PERS	2	18	13	17
Personal Care	2	59	53	18
Respite	2	14	14	6
Telemonitoring	2	3	3	3
Greenville				
Adult Day Health	3	9	8	5
Case Management	3	0	14	4
Home Delivered Meals	3	6	6	4
PERS	3	22	19	18
Personal Care	3	78	76	31
Respite	3	17	15	13

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Telemonitoring	3	5	5	5
Greenwood				
Adult Day Health	2	4	2	4
Case Management	2	1	15	6
Home Delivered Meals	2	6	5	3
PERS	2	19	16	16
Personal Care	2	57	54	24
Respite	2	16	13	10
Telemonitoring	2	3	3	2
Hampton				
Adult Day Health	2	5	3	3
Case Management	2	0	11	5
Home Delivered Meals	2	3	4	3
PERS	2	17	15	16
Personal Care	2	37	30	12
Respite	2	14	11	4
Telemonitoring	2	4	4	4
Horry				
Adult Day Health	2	6	N/A	3
Case Management	2	1		7
Home Delivered Meals	2	3		2
PERS	2	18		17
Personal Care	2	56		17
Respite	2	15		5
Telemonitoring	2	3		2
Jasper				
Adult Day Health	2	5	3	3
Case Management	2	0	11	4
Home Delivered Meals	2	3	4	3
PERS	2	17	15	16
Personal Care	2	38	30	16
Respite	2	15	11	6
Telemonitoring	2	4	3	4
Kershaw				
Adult Day Health	2	11	15	5
Case Management	2	1	14	5
Home Delivered Meals	2	4	5	3

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
PERS	2	19	15	18
Personal Care	2	63	59	26
Respite	2	20	17	11
Telemonitoring	2	3	3	3
Lancaster				
Adult Day Health	2	7	N/A	3
Case Management	2	0		3
Home Delivered Meals	2	3		2
PERS	2	18		15
Personal Care	2	55		20
Respite	2	17		12
Telemonitoring	2	3		2
Laurens				
Adult Day Health	2	4	2	4
Case Management	2	1	15	6
Home Delivered Meals	2	7	6	4
PERS	2	20	17	17
Personal Care	2	69	69	31
Respite	2	18	15	12
Telemonitoring	2	5	5	4
Lee				
Adult Day Health	2	4	5	5
Case Management	2	1	14	5
Home Delivered Meals	2	4	5	3
PERS	2	19	16	17
Personal Care	2	54	47	15
Respite	2	18	14	7
Telemonitoring	2	3	3	3
Lexington				
Adult Day Health	2	10	12	7
Case Management	2	1	16	7
Home Delivered Meals	2	3	4	3
PERS	2	17	17	17
Personal Care	2	84	73	33
Respite	2	18	16	10
Telemonitoring	2	4	4	4
Marion				

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Adult Day Health	2	3	4	3
Case Management	2	1	12	6
Home Delivered Meals	2	3	4	3
PERS	2	18	16	18
Personal Care	2	56	53	20
Respite	2	15	14	5
Telemonitoring	2	3	3	3
Marlboro				
Adult Day Health	2	3	5	2
Case Management	2	2	8	3
Home Delivered Meals	2	3	4	3
PERS	2	19	15	17
Personal Care	2	46	42	17
Respite	2	14	13	6
Telemonitoring	2	3	3	3
McCormick				
Adult Day Health	2	2	2	3
Case Management	2	0	15	3
Home Delivered Meals	2	4	5	4
PERS	2	18	16	17
Personal Care	2	39	38	16
Respite	2	13	10	6
Telemonitoring	2	3	3	3
Newberry				
Adult Day Health	2	10	13	10
Case Management	2	1	13	6
Home Delivered Meals	2	5	6	5
PERS	2	18	16	17
Personal Care	2	61	54	25
Respite	2	17	13	8
Telemonitoring	2	3	3	3
Oconee				
Adult Day Health Care	2	5	4	2
Case Management	2	0	10	2
Home Delivered Meals	2	5	5	3
PERS	2	21	19	17
Personal Care	2	52	49	20

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Respite	2	18	14	6
Telemonitoring	2	4	4	3
Orangeburg				
Adult Day Health	2	14	14	7
Case Management	2	1	14	7
Home Delivered Meals	2	3	5	3
PERS	2	17	15	17
Personal Care	2	72	62	23
Respite	2	14	14	9
Telemonitoring	2	4	4	4
Pickens				
Adult Day Health	2	6	4	3
Case Management	2	0	14	3
Home Delivered Meals	2	6	6	3
PERS	2	21	19	17
Personal Care	2	65	64	29
Respite	2	17	14	12
Telemonitoring	2	5	5	4
Richland				
Adult Day Health	3	14	15	8
Case Management	3	1	15	6
Home Delivered Meals	3	4	4	4
PERS	3	18	16	17
Personal Care	3	96	83	38
Respite	3	19	16	12
Telemonitoring	3	4	4	4
Saluda				
Adult Day Health	2	6	8	3
Case Management	2	1	16	3
Home Delivered Meals	2	5	5	4
PERS	2	18	15	17
Personal Care	2	48	48	21
Respite	2	14	11	7
Telemonitoring	2	3	3	3
Spartanburg				
Adult Day Health	3	6	6	6
Case Management	3	1	12	5

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Home Delivered Meals	3	6	6	3
PERS	3	20	18	17
Personal Care	3	76	73	30
Respite	3	18	14	14
Telemonitoring	3	5	5	5
Sumter				
Adult Day Health	2	6	9	7
Case Management	2	3	16	6
Home Delivered Meals	2	5	7	3
PERS	2	19	15	17
Personal Care	2	68	63	22
Respite	2	19	16	9
Telemonitoring	2	3	3	2
Union				
Adult Day Health	2	8	8	7
Case Management	2	1	9	4
Home Delivered Meals	2	4	4	3
PERS	2	18	17	16
Personal Care	2	51	50	23
Respite	2	16	14	10
Telemonitoring	2	4	4	4
Williamsburg				
Adult Day Health	2	5	8	4
Case Management	2	1	15	7
Home Delivered Meals	2	4	5	4
PERS	2	18	15	17
Personal Care	2	54	50	17
Respite	2	15	14	6
Telemonitoring	2	3	3	3
York				
Adult Day Health	2	6	N/A	5
Case Management	2	0		3
Home Delivered Meals	2	3		2
PERS	2	17		15
Personal Care	2	56		21
Respite	2	18		12
Telemonitoring	2	3		2

County	Minimum Required	Molina Unique Providers	Select Health Unique Providers	Wellcare Unique Providers
Total that Met Minimum (Sum of all services across the total number of counties with minimum required providers met)		281	249	321
Total Required (Sum all of services across the total number of counties)		322	249	322
Percentage MET		87%	100%	99.7%
VALIDATION DECISION		Partially Met	Met	Met

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

The CICOs are also required to have a network of Behavioral Health (BH) providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older), and at least one of the behavioral health providers used to meet the two providers per 50-mile requirement must be a Community Mental Health Center (CMHC). Select Health and Wellcare met these requirements. Molina did not meet the requirements for two counties. The following is an overview of the findings.

Molina - Molina provided information regarding their in-network BH providers. The file demonstrated 100% of members had access to at least two BH providers and one CMHC in that access area. Allendale County did not meet the 90% standard for an opioid treatment clinic nor a psychologist provider group. Bamberg County did not meet the 90% standard for the opioid treatment clinic. This is similar to the previous year's findings.

Select Health - Information on BH providers was submitted to the desk materials. The requirements as set forth by the State were compared to submitted information. The GeoAccess reports showed providers for Metro areas, at least 99.9% of members have access to inpatient providers, and 99.5% of members have access to outpatient providers. 100% of members have access to a CMHC.

For micro and rural areas, the analysis showed 100% of members located in micro or rural areas have access to inpatient and outpatient providers and have access to a CMHC.

Wellcare - Wellcare submitted information about its BH provider network. The requirements set forth by the State were compared to the submitted information. The GeoAccess Network Analysis report provided by Quest Analytics showed that 99.2% of the members have access to a psychiatrist; 98.4% have access to a psychologist; 99.9% have access to a social worker; and 99.9% have access to a CMHC. Analysis was conducted for large metro, metro, micro, rural, and counties with extreme access considerations. Wellcare met all network adequacy requirements for BH providers.

Table 48: Provider Network Adequacy Comparative Data provides an overview of each plan's score for the Provider Network Adequacy section.

Table 48: Provider Network Adequacy Comparative Data

Standard	Molina	Select Health	Wellcare
Provider Network Adequacy			
The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Partially Met ↓	Met	Met
The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Met	Met

B. Evaluation of Over- and Under-Utilization

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

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

The CICOs conducted an analysis of utilization data to evaluate the effectiveness of program interventions and to identify any opportunities to modify and improve these programs. The documentation showed monitoring and analysis of trended data to ensure resources are applied and interventions are implemented to improve appropriate utilization. *Table 49: CICO Over and Underutilization Data* provides each CICO's over and under-utilization reported results for each measure.

Table 49: CICO Over and Underutilization Data

CICO	Measure	Reported Value
Molina	Hospitalization Length of Stay Rate	Declined from 7.9 days to 7.3 days
	Skilled Nursing Facilities Length of Stay Rates	Declined from 21.4 days to 18.3 days
	ER utilization rate	Declined from 907 per 1000 enrollees to 783 per 1000 enrollees

CICO	Measure	Reported Value
	Readmissions	Declined from 61 in the previous year to 46 in the current year
	Members Receiving Behavioral Health Services	Rate Increased from 7.9% to 8.5%.
Select Health	30-Day Hospital Readmission	16.3% 2-30 day readmit as of July 2023
	Inpatient Length of Stay	11.0 (3-month trend)
	Skilled Nursing Facilities Length of Stay	14.4 (3-month trend)
	ER Utilization	116.3 visits per 1000 members
	Behavioral Health Outpatient Penetration/Behavioral Health Inpatient Penetration	.70 per 1000 members/.70 per 1000 members
Wellcare	Inpatient Length of Stay	Increased from 10.5 to 11.5 in quarter 3 and was above the expected value.
	Readmissions	Declined from 13.97% in quarter 1 to 12.50% in quarter 3 and remain below the expected rate of 14.5%.
	Behavioral Health Services	Rate was 2.3% in September 2023, which was a reduction from January 2023 of 5.0%.
	Skilled Nursing Facility Length of Stay	Increase from 21.73 days in quarter 1 to 24 days in quarter 4.
	ER Visits per 1000	Decreased in the latest measurements July (858.3) to August (751.2). The goal value is not clearly documented.

The CICOs met the requirements for evaluating over- and under-utilization as shown in *Table 50: Evaluation of Over/Under Utilization Comparative Data*.

Table 50: Evaluation of Over/Under Utilization Comparative Data

Standard	Molina	Select Health	WellCare
Evaluation of Over/Under Utilization			
The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement.	Met	Met	Met
Length of stay for hospitalizations	Met	Met	Met
Length of stay in nursing homes	Met	Met	Met
Emergency room utilization	Met	Met	Met
Number and percentage of enrollees receiving mental health services	Met	Met	Met

C. Care Transitions

Constellation Quality Health reviewed each CICO's Program Descriptions and policies related to care transitions. The CICOs were required to submit a file of enrollees who were hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. The CICOs were directed to only include those enrollees readmitted with a diagnosis that met the definition of a potentially avoidable hospitalization. These were defined by SCDHHS as Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers. Based on the file received from each CICO, a random sample of files was requested for review. An overview of the findings for Care Transitions follows.

Molina's files lacked documentation demonstrating collaboration with the facility Case Manager or Discharge Planning staff to ensure a safe transition. Two files did not contain documentation of any needed clinical and non-clinical support(s), transition/aftercare appointments, and any barriers for after-care. Some files lacked documentation of outreach to the member to conduct the 72-hour follow-up post discharge and medication monitoring adherence. Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done. These findings were similar to the 2022 EQR findings.

Most files from the Select Health sample reflected that assessments and reassessments were being conducted as required. 13 files reflected that no attempts to contact the facility's Case Management/Discharge Planning staff or the member's PCP, an assessment or reassessment was not completed, and no documentation of the medication was monitoring performed after the 72-hour follow-up. Similar issues were identified during the 2022 EQR. Files where the transition occurred after the implementation of the quality improvement plan, noted improvements for the 2023 EQR documentation and collaboration with the facility case managers and the member's PCP. Issues with this collaboration for five files were found. There was also no documentation of the medication monitoring performed after the 72-hour follow-up for five files.

Several Wellcare files reflected no attempts to contact the facility's Case Management/Discharge Planning staff or the member's PCP, and untimely attempts to contact members/caregivers within 72-hours of discharge. These were issues identified during the 2022 EQR. Wellcare addressed this deficiency with a Quality Improvement Plan and some of these transitions occurred prior to the implementation of that plan.

Table 60 provides an overview of the CICOs scores for the Care Transitions section.

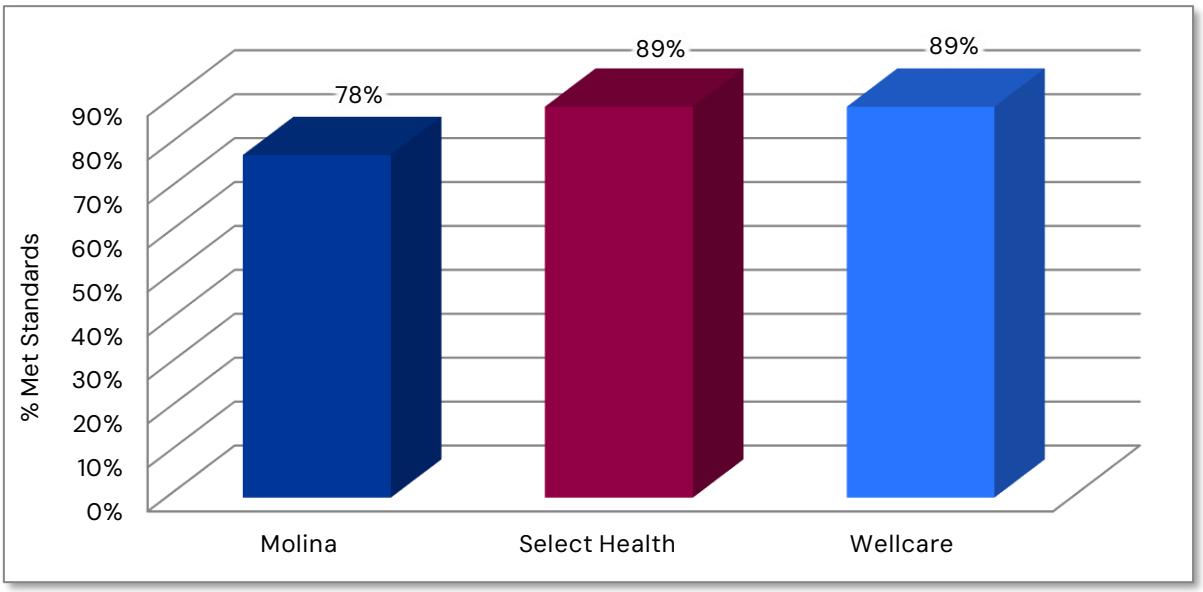
Table 60: Care Transitions Comparative Data

Standard	Molina	Select Health	WellCare
Care Transitions			
The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions	Not Met ↓	Partially Met ↑	Partially Met
Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes	Met	Met	Met

Conclusions

The 2023 - 2024 Annual EQR of the CICOs found that Molina received "Met" scores for 78% of the standards. Network Adequacy and Care Transitions were the areas not meeting the requirements. Select Health and Wellcare received "Met" scores for 89% of the standards. The assessment of the CICOs strengths and weaknesses are included in tables 70 and 71.

Figure 14: CICO's Percentage of Met Standards



Scores were rounded to the nearest whole number.

Table 70: CICO Strengths

Strengths	Quality	Timeliness	Access to Care
The CICOs maintained a network of behavioral health providers that is sufficient to provide all enrollees with access to covered services.			✓
The CICOs conducts an analysis of utilization data to identify any opportunities to modify and improve their programs.	✓		

Table 71: CICO Weaknesses and Recommendations

Weaknesses	Recommendations	Quality	Timeliness	Access to Care
The CICOs are not conducting the appropriate care transitions functions as required by the contract to minimize unnecessary complications.	Develop a plan to audit a sample of case management files to assess compliance with contract requirements. Include additional staff training as needed.	✓		

Healthy Blue Readiness Review

At the request of SCDHHS, Constellation Quality Health conducted a Readiness Review for Healthy Blue, a new MCO providing services for the Healthy Connections population in SC. The objective of the review was to determine if Healthy Blue has the necessary administrative structure, staffing, policies and procedures, support services, provider availability, and member educational materials in place to: 1) commence enrollment, 2) deliver the contractually required services to members, and 3) prepare and submit contractually required reports to SCDHHS.

The process Constellation Quality Health used for the Readiness Review is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for the EQR of Medicaid MCOs. A summary of the Readiness Review results follows.

A. Administration

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

Healthy Blue has appropriate processes for developing, managing, and conducting annual review and revision of policies and procedures. The Policy Development, Review, and Management policy (MCD-CP 15) incorrectly stated which committee will approve policies. Policies will use a standard

policy template and will be housed in locations accessible by staff. Staff will be educated about new/revised policies.

All key positions are filled, and staffing projections appear to be adequate. Recruiting activities were in progress for vacant positions.

Healthy Blue's written Compliance Plan described activities to ensure compliance with laws, regulations, and contractual requirements, and included related Organizational Charts, the Compliance Committee Membership List, and the Antifraud Plan. The Antifraud Plan addressed identifying, detecting, and preventing FWA. Related policies and procedures provided additional details about these topics.

The Compliance Officer will report to the Chief Executive Officer, chair the Compliance Committee, and oversee all compliance activities. The Program Integrity Coordinator will work with the Special Investigations Unit to coordinate FWA activities. The Compliance Committee will report through the Managed Care Oversight Committee to the Board of Directors and will meet monthly. A quorum will be established with the presence of 50% of the voting members.

The Compliance Plan, the 2023 Compliance Overview, and the Our Values document (code of conduct) addressed expectations for ethical business conduct, laws and regulations related to FWA, compliance and FWA reporting responsibilities, and reporting methods. All staff will be required to complete compliance training at employment and annually.

Healthy Blue's Pharmacy Lock-in Program will be overseen by the pharmacy benefit manager. The Lock-In SC Medicaid – Healthy Blue SC policy (RX LOCK SC 43150) did not address the timeframe for notifying members of their inclusion in the program.

Processes for ensuring member privacy and confidentiality are documented in policy.

Information Management Systems

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

MCO documentation reflected that information systems, policies, and procedures meet State requirements. Healthy Blue follows best practices for monitoring and responding to security issues and performs audits to validate performance of system controls.

Table 72: Administration Findings displays the scoring for each standard in the Administration section of the Readiness Review.

Table 72: Administration Findings

Standard	Score
General Approach to Policies and Procedures	
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Partially Met
Policies and procedures are organized in a consistent, understandable format identifiable to applicable line(s) of business under review	Met
Policies and procedures will be updated on a routine basis at a minimum of every two years	Met
Organizational Chart / Staffing	
The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED))	Met
Chief Financial Officer (CFO)	Met
*Contract Manager	Met
Information Systems Personnel Claims and Encounter Manager/ Administrator	Met
Network Management Claims and Encounter Processing Staff	Met
Utilization Management (Coordinator, Manager, Director)	Met
Pharmacy Director	Met
Utilization Review Staff	Met
*Case Management Staff	Met
*Quality Improvement (Coordinator, Manager, Director)	Met
Quality Assessment and Performance Improvement Staff	Met
*Provider Services Manager	Met
*Provider Services Staff	Met
*Member Services Manager	Met
Member Services Staff	Met
*Medical Director	Met
*Compliance Officer	Met
Program Integrity Coordinator	Met
Compliance /Program Integrity Staff	Met
*Program Integrity FWA Investigative/Review Staff	Met
*Interagency Liaison	Met
Legal Staff	Met
*Behavioral Health Director	Met
Operational relationships of MCO staff are clearly delineated	Met
Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*	
The MCO processes provider claims in an accurate and timely fashion	Met
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met
The MCO tracks enrollment and demographic data and links it to the provider base	Met
The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities	Met

Standard	Score
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Met
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met
The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented	Met
Compliance/Program Integrity	
The MCO has a Compliance Plan to guard against fraud and abuse	Met
The Compliance Plan and/or policies and procedures address requirements, including: • Standards of conduct • Identification of the Compliance Officer and Program Integrity Coordinator • Inclusion of an organization chart identifying names and titles of all key staff • Information about the Compliance Committee • Compliance training and education • Lines of communication • Enforcement and accessibility • Internal monitoring and auditing • Response to offenses and corrective action • Data mining, analysis, and reporting • Exclusion status monitoring	Met
The MCO has an established committee responsible for oversight of the Compliance Program	Met
The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met
The MCO's policies and procedures define how investigations of all reported incidents are conducted	Met
The MCO has processes in place for provider payment suspensions and recoupments of overpayments	Met
The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Partially Met
Confidentiality *42 CFR § 438.224*	
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met

B. 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

Member rights and responsibilities are outlined consistently in Policy MCD-CST 18, Member Rights and Responsibilities, the Member Handbook, and Provider Manual. Materials indicate that rights and responsibilities will be made available on the Healthy Blue website and that members will receive a copy in the initial enrollment kit.

Healthy Blue provides new member materials within 14 calendar days after receiving the members' enrollment data from SCDHHS. This information includes how routine and emergent services are defined with instructions for accessing care and resources at the appropriate level. Printed

materials are available to members in other formats, reading levels, and in alternate languages as needed.

Steps for PCP selection are outlined in the Member Handbook and on the website. Assistance is available by contacting the Customer Services Call Center. The Member Handbook describes preventive care and services to help control and prevent communicable diseases for members at different developmental stages and for special populations. Disenrollment information is found in the Member Handbook and Provider Manual, and will be available on the website.

Policy MCD-QM 15, Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, details Healthy Blue's annual processes for assessing child and adult member experiences using CAHPS surveys. The policy notes that the plan will use Press Ganey, an accredited vendor, for the survey administration and the vendor will ensure the sample is statistically valid. The policy mentions that "actions will be implemented to address the opportunities for improvement" but does not specify which department or committee will be the primary party responsible for developing and tracking any action steps. The analysis and implementation of interventions to improve member satisfaction are discussed during the appropriate internal committee meetings.

Grievances

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

Healthy Blue's process for handling member grievances is described in Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual. Grievances may be filed at any time verbally or in writing. However, Healthy Blue's Member Handbook did not inform the member that a grievance may be filed at any time as allowed by the *SCDHHS Contract, Section 9.1.1.2.1.*

Per Policy MCD-CST 17, Member Grievance Process, Healthy Blue will acknowledge a grievance in writing within seven days of receipt of the grievance. However, the Provider Manual incorrectly states "Healthy Blue sends a written acknowledgement of the grievance or appeal to the member within five calendar days from the date of receipt."

Grievances will be resolved within 90 days of receipt of the grievance. The *SCDHHS Contract, Section 9.1.6.1.4* allows Healthy Blue to request an extension if there is a need for additional information and the delay is in the member's best interest. The contract requires Healthy Blue to notify the member of the delay and inform them of their right to file a grievance (*SCDHHS Contract, Section 9.1.6.1.5.2*). Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and the Provider Manual did not include the requirement to inform the member of the right to file a grievance if he or she disagrees with Healthy Blue's request to extend the timeframe for resolution. Also, the Provider Manual did not include the requirement to provide the member with prompt oral notice of the delay followed by written notice within two calendar days (*SCDHHS Contract, Section 9.1.6.1.5.2*).

Table 73: Member Services Findings displays the scoring for each standard in the Members Services section of the Readiness Review.

Table 73: Member Services Findings

Standard	Score
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*	
The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities	Met
Member rights include, but are not limited to, the right: • To be treated with respect and with due consideration for dignity and privacy • To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand • To participate in decision-making regarding their health care, including the right to refuse treatment • 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 • To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164) • 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	Met
Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*	
Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: • Benefits and services included and excluded in coverage • Direct access for female members to a women's health specialist in addition to a PCP • Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary • How members may obtain benefits, including family planning services from out-of-network providers • Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits • Any requirements for prior approval of medical or behavioral health care and services • Procedures for and restrictions on obtaining out-of-network medical care • Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services • Policies and procedures for accessing specialty care • Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions • Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network • Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care • Procedures for disenrolling from the MCO • Procedures for filing grievances and appeals, including the right to request a Fair Hearing	Met

Standard	Score
• Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office • Instructions on how to request interpretation and translation services at no cost to the member • Member's rights, responsibilities, and protections • Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them • A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services • How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary • Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services • A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive • Information on how to report suspected fraud or abuse • Additional information as required by the contract and/or federal regulation	
Members are notified at least once per year of their right to request a Member Handbook or Provider Directory	Met
Members are informed in writing of changes in benefits and changes to the provider network	Met
Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met
The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO	Met
Member Enrollment and Disenrollment *42 CFR § 438.56*	
The MCO enables each member to choose a PCP upon enrollment and provides assistance, if needed	Met
MCO-initiated member disenrollment requests are compliant with contractual requirements	Met
Preventive Health and Chronic Disease Management Education	
The MCO informs members of available preventive health and disease management services and encourages members to utilize these services	Met
The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits	Met
The MCO provides education to members regarding health risk factors and wellness promotion	Met
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care	Met
Member Satisfaction Survey	
The MCO has a system in place to conduct a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	Met
Statistically sound methodology, including probability sampling to ensure it is representative of the total membership	Met
The availability and accessibility of health care practitioners and services	Met
The quality of health care received from MCO providers	Met
The scope of benefits and services	Met

Standard	Score
Claim processing procedures	Met
Adverse MCO claim decisions	Met
The MCO analyzes data obtained from the member satisfaction survey to identify quality issues	Met
The MCO implements significant measures to address quality issues identified through the member satisfaction survey	Met
The MCO reports the results of the member satisfaction survey to providers	Met
The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee	Met
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*	
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	Met
The definition of a grievance and who may file a grievance	Met
Procedures for filing and handling a grievance	Partially Met
Timeliness guidelines for resolution of a grievance	Partially Met
Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee	Met
Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Met
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met

C. Quality Improvement

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

Healthy Blue has developed a Quality Improvement (QI) Program with an overall goal to improve the quality and safety of clinical care and services provided to members. The 2024 Healthy Blue Medicaid Quality Management and Improvement Program Description included 11 specific goals to help achieve this overall goal. The scope of the program encompasses clinical care and service monitoring, evaluation, analysis, and improvements. The program's structure and staffing resources were outlined in the Program Description, however, staffing only included the senior level staff resources. There were several positions not mentioned. Also, the Program Description (pages 10-13) discusses the program's methodology; however, the "Quality Improvement Model" (page 12) appeared to be a bulleted list of interventions and was not specific regarding which QI model Healthy Blue plans to use. There was also missing information regarding the data sources (page 12).

Policy MCD-UM 22, Under and Over Utilization of Services, describes the process that will be used to investigate trends noted through the analysis of over- and underutilization trends. Annually, reports are analyzed against benchmarks to determine patterns. The policy indicates areas of review may include ER utilization, frequency of dental examinations, and frequency of selected

procedures. There was no mention in this policy of including any inpatient data, such as inpatient length of stay or behavioral health measures. Information on who will set the targets/thresholds and how they will be chosen are also not included in the policy. There was no documentation on the action steps that will be taken if over- or underutilization is identified. The policy states "interventions are identified for implementation" but there is no information on how this occurs and if there is a timeframe for corrective actions.

Annually, Healthy Blue will develop a QI Work Plan that will include specific activities and objectives, the responsible staff, and the specific timeframe for completion of each activity. A sample QI Work Plan was provided. Healthy Blue views this work plan as a dynamic document that will be updated frequently.

Healthy Blue's Clinical Quality Improvement Committee is the committee responsible for providing oversight and direction of the QI Program. This committee reports to the Board of Directors and is co-chaired by the health plan's Medical Director and Vice President, Healthy Blue MCO. Voting members will include five fully credentialed and actively participating providers. At least three network providers present at the meetings are needed for a quorum.

Network providers are supported through an assigned Quality Navigator, who is responsible for educating providers on current HEDIS requirements and members' gaps in care reporting. The gaps in care reports assist the providers in identifying members who have not completed their annual care. Onsite medical office reviews are also conducted to identify areas of improvement opportunities.

Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, discusses the review, adoption, and dissemination of the preventive health and clinical practice guidelines. However, this policy does not address the monitoring process to ensure providers adhere to these guidelines.

At least annually, Healthy Blue will formally conduct an evaluation of the QI Program, which will address the overall effectiveness of the QI Program and include the program's accomplishments, an outcomes analysis and evaluation to determine the extent to which the quality activities were completed, and goals met. The evaluation will also include any recommended interventions or actions needed for the upcoming year. The annual evaluation will be presented to the Clinical Quality Improvement Committee for recommendations and final approval.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

For the performance measure validation, Constellation Quality Health reviewed Healthy Blue's plan for collecting and reporting HEDIS measures. There were two policies submitted related to the specific aspects of HEDIS measures. Policy MCD-DM 22, Healthcare Effectiveness Data and Information Set (HEDIS) Record Abstraction Documentation Compliance, offers the policy for

record abstraction documentation compliance such as training and Inter-Rater Reliability. Policy MCD-DM 23, Healthcare Effectiveness Data and Information Set (HEDIS) Chase Logic Documentation, offers the chase logic documentation and refers to the cross walking and mapping. The overall HEDIS calculation-based policies and procedures were not included. The policies should outline a broader overview of the HEDIS procedures that will be used, including documentation.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

Policy MCD-QM 17, Performance Improvement Projects- Study Selection, Design, Implementation and Evaluation Process, noted the topics for the performance improvement projects will be selected based on plan level data that identifies areas for improvement such as HEDIS and CAHPS data. The policy does not indicate that other performance data, based on priority topics or utilization data, or other system data may be included as part of the Performance Improvement Project (PIP). Although a majority of the PIP topics are derived from HEDIS rates, it is important to maintain a broad scope of possible indicators for assessing quality. As such, the policy should be inclusive of measures beyond HEDIS and CAHPS, including utilization or other plan-developed measures. Additionally, if data are derived outside of the CAHPS and HEDIS specifications, a general plan for data collection and validation should be included in the policy.

Healthy Blue provided a PIP template to document the PIPs. This template did not include all the elements that are required by the CMS protocol. The indicator description includes a narrative of the numerator and denominator and the baseline goal and benchmark rates. A section to show the sampling methodology is also required per the protocol. The data collection sources, methodology, personnel, and data analysis plan are not included as variables in the PIP template. The results should contain the numerator, denominator, rate, and benchmark or goal rate, and a place for statistical significance testing, when sampling is applied.

Table 74: Quality Improvement Standards and Scores displays scores for the individual standards. Areas related to the QI Program Description, the performance measures, QI projects, and provider monitoring were areas that received a "Partially Met" score as noted in the following graphs.

Table 74: Quality Improvement Standards and Scores

Standard	Score
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*	
The MCO has a system in place for implementing a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Partially Met

Standard	Score
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Partially Met
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met
Quality Improvement Committee	
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met
The composition of the QI Committee reflects the membership required by the contract	Met
The QI Committee meets at regular quarterly intervals	Met
Minutes will be maintained that document proceedings of the QI Committee	Met
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*	
The process for collecting and reporting the performance measures are consistent with the requirements of the contract	Partially Met
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*	
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Partially Met
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met
Provider Participation in Quality Improvement Activities	
The MCO requires its providers to actively participate in QI activities	Met
Providers will receive interpretation of their QI performance data and feedback regarding QI activities	Partially Met
Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*	
A written summary and assessment of the effectiveness of the QI program will be prepared annually and submitted to the QI Committee and to the MCO Board of Directors	Met

D. Utilization Management

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

The Medicaid Integrated Care Management Plan, Pharmacy Program Description, and various policies outline Healthy Blue's Utilization Management (UM) scope and objectives for physical health, behavioral health, and pharmacy services.

The Chief Medical Director provides overall oversight of the UM Program, and another Medical Director manages the day-to-day UM operations. The Behavioral Health Medical Director and Chief Pharmacy Officer provide clinical oversight of their respective programs.

UM reviewers are licensed practitioners within their respective healthcare disciplines, and make initial clinical determinations utilizing individual member circumstances and clinical criteria,

including Milliman Clinical Guidelines (MCG) and internal evidence based clinical criteria. However, the guidelines and standards were not outlined in policy or in the Program Descriptions. Training is provided to UM Reviewers at hire and on an ongoing basis to ensure accountability and consistency in standard authorization reviews. Preceptors also serve as Peer Team Leaders to provide technical assistance and feedback to review staff. In the event of a potential adverse benefit decision, a second level review is conducted by a licensed physician with appropriate clinical expertise in treating the member's condition or disease.

Healthy Blue's Preferred Provider Program is offered to providers with an 80% or greater approval rate of authorizations and is audited annually to ensure continual participation.

Appeals

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

Healthy Blue's appeal process is outlined in the Provider Manual, Member Handbook, Staff Utilization Review Manual, various Program Descriptions, and policies. Constellation Quality Health reviewed Healthy Blue's appeal processes and found issues with the definition of an appeal, the procedures for filing an appeal, timeliness for notification and resolution of an appeal, and the continuation of benefits. A quarterly appeal analysis is conducted, and the findings are presented to the Service Quality Improvement Committee for trends and opportunities for improvement. Also, quarterly appeal logs are submitted to SCDHHS.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

The Medicaid Integrated Care Management Plan and various policies outline the scope, purpose, and objectives of Healthy Blue's Care Management Program for South Carolina members.

Healthy Blue's Integrated Care Management Plan describes various referral sources that aid in identifying potential members for case management services. Once a referral is initiated, an initial assessment is conducted to aid in care plan development, and care management activities are conducted to address the members' identified needs.

Over/Underutilization

A policy, MCS-UM-22, Under and Over Utilization of Services, was submitted as part of the over- and underutilization review. The policy described the process Healthy Blue will use to investigate trends noted through the analysis of over- and underutilization trends. Annually, trend reports are analyzed against benchmarks to determine patterns. The areas of review may include ER utilization, frequency of dental examinations, and frequency of selected procedures. There is no documentation of the action steps that will be taken if over- or under-utilization is identified. The policy states "interventions are identified for implementation" but there is no information on how this occurs, and if there is a timeframe for corrective actions. Also, information on who will set the targets/thresholds and how they

will be chosen is not included in the policy. The policy should indicate what department will set the thresholds for over- and underutilization, and the source for those thresholds (national benchmarks). Areas needing improvement were found in the appeals section of the UM section. *Table 75: Utilization Management Findings* shows the scores for each standard.

Table 75: Utilization Management Findings

Standard	Score
The Utilization Management (UM) Program	
The MCO has in place policies and procedures that describe its utilization management program, including but not limited to:	Met
structure of the program and methodology used to evaluate the medical necessity	Met
lines of responsibility and accountability	Met
guidelines / standards to be used in making utilization management decisions	Met
timeliness of UM decisions, initial notification, and written (or electronic) verification	Met
consideration of new technology	Met
the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met
the mechanism to provide for a preferred provider program	Met
Utilization management activities will occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met
The UM program design will be periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met
Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*	
Utilization management standards/criteria to be used are in place for determining medical necessity for all covered benefit situations	Met
Utilization management decisions will be made using predetermined standards/criteria and all available medical information	Met
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met
Utilization management standards/criteria will be consistently applied to all members across all reviewers	Met
Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met
Emergency and post stabilization care will be provided in a manner consistent with the contract and federal regulations	Met
Utilization management standards/criteria are available to providers	Met
Utilization management decisions will be made by appropriately trained reviewers	Met
Initial utilization decisions will be made promptly after all necessary information is received	Met
Denials	Met

Standard	Score
A reasonable effort that is not burdensome on the member or the provider will be made to obtain all pertinent information prior to making the decision to deny service	
All decisions to deny services based on medical necessity will be reviewed by an appropriate physician specialist	Met
Denial decisions will be promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*	
The MCO has in place policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met
The procedure for filing an appeal	Partially Met
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met
Written notice of the appeal resolution as required by the contract	Met
Other requirements as specified in the contract	Partially Met
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the QIC	Met
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met
Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*	
The MCO formulates policies and procedures that describe its case management/care coordination programs	Met
The MCO has processes to identify members who may benefit from case management	Met
The MCO provides care management activities based on the member's risk stratification	Met
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met
The MCO conducts required care management activities for members receiving behavioral health services	Met
Care Transitions activities include all contractually required components. The MCO has developed and implemented policies and procedures that address transition of care	Met
The MCO has a designated Transition Coordinator who meets contract requirements	Met
The MCO measures case management performance and member satisfaction and has processes to improve performance when necessary	Met
Evaluation of Over/ Underutilization	
The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	Met

E. Delegation

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

Healthy Blue delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include utilization management, pharmacy services and credentialing.

For the Readiness Review, Healthy Blue reported 12 delegation agreements, as shown in *Table 76: Delegated Entities and Services*.

Table 76: Delegated Entities and Services

Delegated Entities	Delegated Services
• CarelonRx	• Pharmacy
• National Imaging Associates (NIA)	• Utilization Management
• VSP Vision Care • South Carolina Department of Mental Health • Spartanburg Health/Regional Health Plus • Medical University of South Carolina • Roper St. Francis Physician's Network • AnMed Health • Self Regional Healthcare • HCA Physicians Services Group • Prisma Health • Tenet (HCS Physicians)	• Credentialing

Prior to delegation of health plan functions or services, the Quality Management/Accreditation and Compliance departments conduct pre-delegation assessments. Through this process, Healthy Blue reviews the potential delegate's documentation that demonstrates its ability to perform the delegated functions and/or services in accordance with applicable federal and contractual requirements. For the Readiness Review, pre-delegation assessments were conducted for three entities. Upon completion of these assessments, all three were determined to be compliant with all requirements.

When the pre-delegation assessment is completed and delegation is approved, a written agreement between Healthy Blue and the delegate is implemented. This agreement outlines the delegated activities, performance expectations, monitoring processes, and consequences of noncompliance.

After approval of delegation, annual audits are conducted for each delegated entity. Healthy Blue submitted copies of the annual audits conducted for nine credentialing delegates. The documentation confirmed annual oversight is conducted in a timely manner, and identified issues were documented.

Regular oversight and monitoring activities are conducted for all delegated vendors through the review of routine delegate reporting. Contract owners or business owners are responsible for monitoring the timely and accurate submission of all required reports from the delegated entities and presenting reports to the Compliance Committee. Corrective action plans are issued to resolve compliance or performance issues.

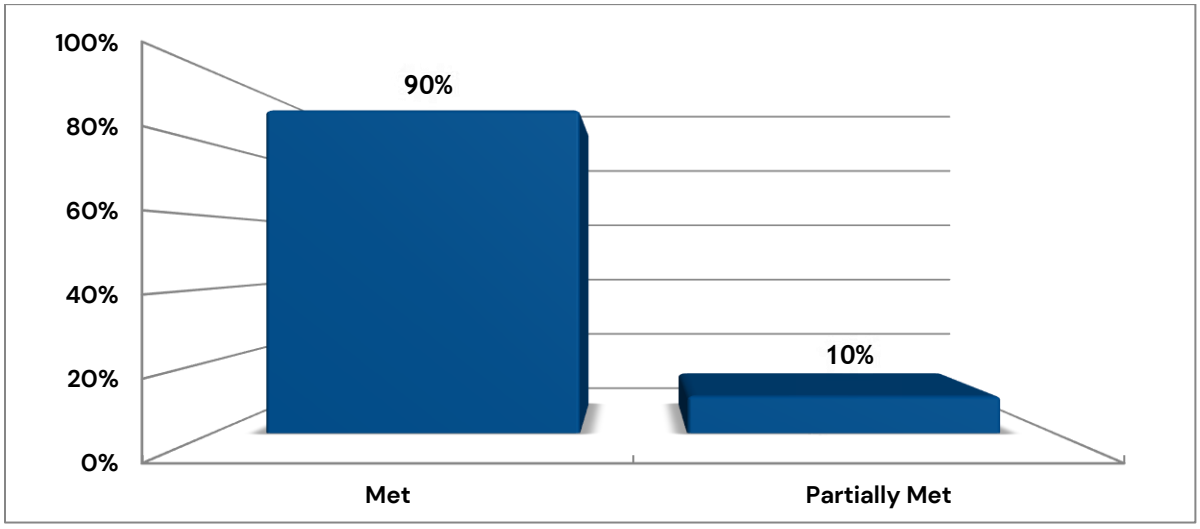
Table 77: Delegation Findings displays the scoring for each standard in the Administration section of the Readiness Review.

Table 77: Delegation Findings

Standard	Score
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*	
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met
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	Met

The Readiness Review shows that Healthy Blue achieved "Met" scores for 90% of the standards reviewed as the following chart indicates. Strengths, weaknesses, and recommendations are found in *Table 78* and *Table 79*.

Figure 15: Healthy Blue Readiness Review Overall Results



Scores were rounded to the nearest whole number

Table 78: Healthy Blue's Readiness Strengths

Strengths	Quality	Timeliness	Access to Care
Administration			
Appropriate processes are in place for developing, managing, reviewing, and revising policies and procedures.	✓		
Key positions are filled. Projected staffing meets contractual requirements and appears to be adequate.	✓		
Healthy Blue has a thorough and well-documented Disaster Recovery Plan.	✓		
Timestamps and revision histories indicate information systems documentation is reviewed and updated regularly.	✓		
The Compliance Plan, Antifraud Plan, and related policies and procedures are comprehensive and address activities conducted to ensure compliance and prevent, detect, and respond to FWA.	✓		
Compliance training is mandatory and provided at employment and annually. In addition, Healthy Blue installs posters related to compliance and FWA in common areas, disseminates electronic bulletins about compliance and FWA topics, and conducts regular compliance awareness activities.	✓		
The Compliance Plan and the 2023 Compliance Overview and Our Values (code of conduct) provide comprehensive information about expectations for ethical business conduct.	✓		
The Privacy and Confidentiality policy (MCD-CP 12) provides detailed, comprehensive information about processes for ensuring member privacy and the confidentiality of protected health information.	✓		
Member Services			
Healthy Blue provides enrollees with a digital member ID card to ensure that access to services is available even when the physical ID may not be available.			✓
Quality Improvement			
Healthy Blue's Clinical Quality Improvement Committee is the committee responsible for providing oversight and direction of the QI Program.	✓		
Network providers are supported through an assigned Quality Navigator. The Quality Navigator's role is to educate providers on current HEDIS requirements, and members' gaps in care reporting.	✓		
Healthy Blue has two policies for HEDIS measure validation that outline specific processes for record abstraction and logic documentation.	✓		
Healthy Blue has a policy to outline the elements of selection, design, implementation, and evaluation in conducting Performance Improvement Projects.	✓		
Utilization Management			
Healthy Blue has a comprehensive training program for UM Reviewers that entails completing training modules, peer shadowing, and Preceptors (Peer Team Leaders) to promote accuracy in clinical application and service authorization processing.	✓		
A quarterly appeal analysis is conducted, and the findings are presented to the Service Quality Improvement Committee for trends and opportunities for improvement. Also, quarterly appeal logs are submitted to SCDHHS.	✓		

Strengths	Quality	Timeliness	Access to Care
Healthy Blue has a policy in place to detect over- and underutilization.	✓		
Delegation			
Prior to delegation, pre-delegation assessments are conducted to determine potential delegates' abilities to successfully perform the delegated functions and/or services in accordance with applicable federal and State requirements.	✓		
Annual audits are conducted for each delegate to determine ongoing compliance with requirements.	✓		
Regular oversight and monitoring activities are conducted for all delegated entities through the review of relevant monthly, quarterly, and annual reports.	✓		

Table 79: Healthy Blue's Readiness Weaknesses and Recommendations

Weakness	Recommendation	Quality	Timeliness	Access to Care
Administration				
Issues noted in policies include: • Policy MCD-CP 15, Policy Development, Review, and Management, incorrectly lists the committee responsible for policy review and approval. • Policy RX LOCK SC 43150, Lock-In SC Medicaid – Healthy Blue SC, does not provide the specific timeframe for notifying members of their inclusion in the program.	Ensure policies contain complete and correct information.	✓		
Member Services				
Policy MCD-QM-15, Consumer Assessment of Healthcare Providers and Systems (CAHPS), notes that "actions will be implemented to address the opportunities for improvement." However, does not specify which department or committee will be responsible for the development or tracking any action steps.	Include the responsible committee(s) that will initiate the interventions and monitor their progress for issues identified in the member satisfaction survey.	✓		
The Member Handbook did not include the wording about the member's ability to file a grievance at any time.	Revise the Member Handbook to include the wording that indicates that a grievance can be filed at any time as referenced in the *SCDHHS Contract, Section 9.1.1.2.1.*	✓		
The timeframe for acknowledging a grievance was incorrect in the Provider Manual.	Correct the timeframe for acknowledging a grievance in the Provider Manual.		✓	
Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual did not include the requirement to inform the member of the right to file a grievance if he or she disagrees	Correct policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual and include the requirement to inform the		✓	

Weakness	Recommendation	Quality	Timeliness	Access to Care
with Healthy Blue's request to extend the timeframe for resolutions. Also, the Provider Manual did not include the requirement to provide the member with prompt oral notice of the delay followed by written notice within two calendar days	member of the right to file a grievance if he or she disagrees with Healthy Blue's request to extend the resolutions timeframe. Also, include the requirement to provide the member with prompt oral notice of the delay followed by written notice within two calendar days if Healthy Blue requests an extension.			
Quality Improvement				
The QI program description lacked details regarding the staff resources, the methodology to be used in implementing the program, and missing information in the Data Sources section on page 12.	The Program Description developed for the QI Program should include details regarding resources needed and methods for implementing the program.	✓		
Policy MCD-UM 22, Under and Over Utilization of Services, did not include a comprehensive list of utilization measures that addresses the entire plan population and service domains. The policy also lacked details regarding the determination of thresholds and the steps taken to address any identified concerns.	The under- and overutilization policies must address the measures and thresholds. The steps taken to address concerns with utilization should be documented, including the initial approach and any escalation to other departments if the utilization issue is not resolved, and the timeline for the escalation.	✓		
The overall HEDIS calculation-based policies and procedures were not addressed in the two HEDIS policies (MCD-DM 22 and MCD-DM 23).	Create a HEDIS administration and calculation policy that addresses the components of external vendors, training of plan staff for vendor applications and systems, a timeline for the general milestones (finalizing vendor contracts, pulling sample frames, preliminary assessment of data to identify issues; start of medical record review and validation, final rate calculations; etc.). Corporate and local health plan staff responsibilities should be outlined in this policy (e.g., Project Leader, compliance team, IT team, etc.).	✓		
Policy MCD-QM 17, Performance Improvement Projects- Study Selection, Design, Implementation and Evaluation Process, noted the topics for the performance improvement projects will be selected based on plan level data that identifies areas for improvement such as HEDIS and CAHPS data. The policy does not indicate that other performance data, based on priority topics or utilization data, or other system data may be included as part of the PIP.	Add language to Policy MCD-QM 17, Performance Improvement Projects- Study Selection, Design, Implementation and Evaluation Process, that reaches a broader spectrum of performance measures under the "Procedure" Section one. Under Section five, add information on how valid and reliable data will be obtained for measures that are non-HEDIS and non-CAHPS.	✓		
Healthy Blue's PIP template to be used for documenting the performance improvement	Develop a PIP template that aligns with the elements or requirements in the CMS protocol.	✓		

Weakness	Recommendation	Quality	Timeliness	Access to Care
projects did not include all the elements that are required by the CMS protocol				
Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, discusses the review, adoption, and dissemination of preventive health and clinical practice guidelines. However, this policy does not address the monitoring to ensure providers adhere to these guidelines.	Include in policy the monitoring conducted to ensure providers adhere to the preventive and clinical practice guidelines.	✓		
Utilization Management				
Healthy Blue described that Milliman Clinical Guidelines (MCG), and internal evidenced based clinical criteria are utilized for making clinical determinations. However, the specific clinical criteria guidelines are not outlined in policy or Program Descriptions.	Include the evidenced based standards and criteria that will be utilized for determining medical necessity in a policy or in the UM Program Description.	✓		
The definitions of an appeal and adverse benefit decision are found in the Member Handbook and Policy MCD-AP-10, Member Appeals Process. However, the definition of an adverse benefit decision is not included in the Provider Manual.	Include the definition of an adverse benefit decision in the Provider Manual.	✓		
There were several identified issues with Healthy Blue's procedures for filing an appeal and the timeliness for notification and resolution of an appeal.	Correct the errors identified in Healthy Blue's Provider Manual, Member Handbook, the Utilization Review Manual, and in policies related to the procedures and processes for filing an appeal and timeliness for notification and resolution of an appeal.		✓	✓
Policy MCD-AP-10, Member Appeals Process, does not provide the guidelines for continuation of benefits for members while in the appeal process.	Update the appeal policy to include the continuation of benefits process for members while in the appeals process as required by *SCDHHS Contract*.			✓

FINDINGS SUMMARY

Overall, Healthy Blue, Humana, Molina, Select Health, and Solutions sustained or showed the most improvements. *Table 80: Scoring Overview* provides an overview of the scoring for each section of the EQR. The percentages highlighted in green indicate the health plan sustained or showed an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings.

Table 80: Scoring Overview

	Met	Partially Met	Not Met	Not Applicable	Total Standards	*Percentage Met Scores
Administration						
ATC	39	1	0	0	40	98%↓
Healthy Blue	40	0	0	0	40	100%
Humana	38	1	1	0	40	95%↑
Molina	40	0	0	0	40	100%
Select Health	40	0	0	0	40	100%
Solutions	30	0	0	0	30	100%↑
Healthy Blue (Readiness Review)	40	2	0	0	42	95%
Provider Services						
ATC	76	4	0	0	80	95%↓
Healthy Blue	74	2	0	0	76	97%↓
Humana	78	1	1	0	80	98%↑
Molina	75	1	0	0	76	99%
Select Health	79	0	1	0	80	99%↑
Solutions	5	0	0	0	5	100%↑
Healthy Blue (Readiness Review)	N/A	N/A	N/A	N/A	N/A	N/A
Member Services						
ATC	32	1	0	0	33	97%↓
Healthy Blue	33	0	0	0	33	100%↑
Humana	31	2	0	0	33	94%
Molina	33	0	0	0	33	100%

	Met	Partially Met	Not Met	Not Applicable	Total Standards	*Percentage Met Scores
Select Health	33	0	0	0	33	100%
Solutions	N/A	N/A	N/A	N/A	N/A	N/A
Healthy Blue (Readiness Review)	30	2	0	0	32	93.8%
Quality Improvement						
ATC	14	0	0	0	14	100%
Healthy Blue	14	0	0	0	14	100%
Humana	12	3	1	0	16	75%↓
Molina	14	0	0	0	14	100%↑
Select Health	16	0	0	0	16	100%
Solutions	7	0	0	0	7	100%
Healthy Blue (Readiness Review)	7	6	0	0	13	53.8%
Utilization Management						
ATC	43	3	0	0	46	93%↓
Healthy Blue	45	1	0	0	46	98%↑
Humana	44	2	0	0	46	96%↑
Molina	43	3	0	0	46	93%
Select Health	42	3	0	0	46	93%↓
Solutions (Care Coordination/Case Management)	14	0	0	0	14	100%↑
Healthy Blue (Readiness Review)	41	4	0	0	45	91.1%
Delegation						
ATC	1	1	0	0	2	50%
Healthy Blue	2	0	0	0	2	100%↑
Humana	1	1	0	0	2	50%↓
Molina	2	0	0	0	2	100%
Select Health	2	0	0	0	2	100%
Solutions	N/A	N/A	N/A	N/A	N/A	N/A
Healthy Blue (Readiness Review)	2	0	0	0	2	100%

	Met	Partially Met	Not Met	Not Applicable	Total Standards	*Percentage Met Scores
Mental Health Parity						
ATC	0	0	2	0	2	0%
Healthy Blue	N/A	N/A	N/A	N/A	N/A	N/A
Humana	2	0	0	0	2	100%
Molina	N/A	N/A	N/A	N/A	N/A	N/A
Select Health	2	0	0	0	2	100%
Solutions	N/A	N/A	N/A	N/A	N/A	N/A
Healthy Blue (Readiness Review)	N/A	N/A	N/A	N/A	N/A	N/A
Totals						
ATC	207	10	2	0	219	95%↓
Healthy Blue	212	3	0	0	215	98.60%↑
Humana	206	10	3	0	219	94%↑
Molina	210	4	1	0	215	98%
Select Health	215	3	1	0	219	98.62%↑
Solutions	56	0	0	0	56	100%↑
Healthy Blue (Readiness Review)	120	14	0	0	134	89.55%

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

Table 81: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons displays a comparison of the total percentage of standards scored as "Met" for the Part 438 Subpart D and QAPI Standards for the 2023—2024 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction from the MCO's prior review. Up (↑) and down (↓) arrows are included to further illustrate the change from the previous reviews.

Table 81: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons

Federal Standards	ATC			Healthy Blue			Humana			Molina			Select Health		
	2023	2022	2021	2023	2022	2021	2024	2023	2022	2023	2022	2021	2023	2022	2021
Disenrollment Requirements and Limitations *(§ 438.56)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Enrollee Rights Requirements *(§ 438.100)*	50%↓	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Emergency and Post-Stabilization Services *(§ 438.114)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Availability of Services (§ 438.206, § 457.1230) Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	75%↓	100%	75%	88%↑	87.5%	87.5%	92%↑	87.5%	100%	88%↑	87.5%	62.5%	92%↑	75%	75%
Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	89%↓	100%	100%	100%	100%	100%
Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	92%↓	100%	92.8%	100%↑	92.8%	100%	100%↑	92.8%	78.5%	93%↑	92.8%	100%	93%↓	100%	100%
Provider Selection *(§ 438.214, § 457.1233)*	98%↑	97%	100%	97%↓	100%	94.8%	98%↓	100%	76.9%	100%	100%	100%	100%	100%	100%

Federal Standards	ATC			Healthy Blue			Humana			Molina			Select Health		
	2023	2022	2021	2023	2022	2021	2024	2023	2022	2023	2022	2021	2023	2022	2021
Confidentiality *(§ 438.224)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	100%	100%	100%	95%↑	90%	95%	85%↓	90%	90%	95%↑	90%	100%	95%↑	90%	100%
Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	50%	50%	100%	100%↑	50%	50%	50%↓	100%	100%	100%	100%	100%	100%	100%	100%
Practice Guidelines *(§ 438.236, § 457.1233)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Information Systems *(§ 438.242, § 457.1233)*	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	100%	100%	100%	100%	100%	100%	75%↓	79%	**90.9%	100%↑	92.8%	92.8%	100%	100%	100%

Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100
***The Standards Not Evaluated were removed from the denominator and numerator*

Attachments

Attachment 1: Assessment of Quality Improvement Plan from Previous EQR

CONSTELLATION QUALITY HEALTH EXTERNAL QUALITY REVIEW

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Absolute Total Care 2022 Quality Improvement Plan

Standards	Absolute Total Care 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
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.	The Credentialing Committee Charter, found on page 13 of the 2022 Quality Program Description, states the committee composition includes network practitioners; however, the 2022 committee roster indicates one external practitioner member of the committee is not a network provider. During onsite discussion of this finding, ATC staff reported that non-participating providers may serve as members of the Credentialing Committee. This is not in compliance with footnote number 5 on page 3 of Policy CC.CRED.03, Credentialing Committee, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers." *Quality Improvement Plan: To comply with requirements of Policy CC.CRED.03, Credentialing Committee, replace the non-participating practitioner member of the Credentialing Committee with a network practitioner.*	✓	
DELEGATION			
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	No annual oversight documentation was submitted for Envolve People Care Behavioral Health. During onsite discussion, ATC staff stated that an annual evaluation was conducted in 2022, but that delegation would not continue for this delegate in 2023. ATC confirmed they would submit evidence of the 2022 annual evaluation; however, no documentation was received. ATC's documentation reflects that this delegate conducts behavioral health service authorizations and medical necessity denials, along with associated member and provider notice of adverse benefit determination letters, and provider generated complaints. Documentation of annual oversight for the remaining delegates included appropriate audit and file review tools, and documentation of results, recommendations, and any needed corrective actions.		✓

Standards	Absolute Total Care 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	Policy CC.CRED.12, Oversight of Delegated Credentialing, states the plan monitors delegate performance in a variety of ways, including by conducting at least annual evaluations to assess performance. • Section III (C) of the policy states summaries of routine oversight meetings and evaluation of interim reporting are presented at the next regularly scheduled Credentialing and/or QIC for review and approval. • Section IV (E) states a summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities and presented to the Credentialing and/or QIC for review and approval. • Section V (E) states reports about any ongoing corrective action plans will be presented to Plan Credentialing/QIC at least quarterly. During onsite discussion with staff responsible for delegation oversight activities, it was confirmed that annual oversight evaluations are conducted by corporate staff, and that results of the annual oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). Review and discussion of the reports of non-credentialing delegation were clearly noted in the QIC minutes submitted for review. However, the Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight, specifically the items specified in Policy CC.CRED.12 (noted above). During onsite discussion, it was reported that the Credentialing Committee minutes submitted for review were the final minutes. Binders attached to the QIC minutes included copies of Credentialing Committee minutes; however, discrepancies were noted for two sets of minutes when compared to the submitted minutes. After completion of the onsite review, a statement was received from ATC/Centene staff that the originally submitted minutes were not final. Further, the 2021 QI Program Evaluation, page 117, indicates that for all Credentialing delegates, the Credentialing Committee reviewed the results of credentialing delegate audits during the February 8, 2022 meeting. Upon re-examination of the originally submitted Credentialing Committee minutes, as well as the minutes attached to the QIC binders, there was no evidence identified to support this. *Quality Improvement Plan: Ensure annual evaluations are conducted for each delegated entity. To comply with requirements of Policy CC.CRED.12, Oversight of Delegated Credentialing, implement actions to ensure that either the QIC or Credentialing Committee receives and reviews summaries of routine oversight meetings, evaluations of interim*		

Standards	Absolute Total Care 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	reporting, a summary of the annual delegation review via the Report of Delegation Oversight Activities, and reports about any ongoing corrective action plans.		

Healthy Blue 2022 Quality Improvement Plan

Standards	Healthy Blue 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
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 MCD-11, Medicaid Access/Availability Standard, lists appointment access standards. The "Physician Office Accessibility Standards" table on page 4 of the policy states "routine care appointments should be scheduled within four weeks of request." However, the last line of the table states, "Health Maintenance and Preventative Care –To meet criteria, appointments should be scheduled within 8 weeks." The Provider Manual, page 115, also lists the additional standard for Health Maintenance and Preventative Care. This finding was discussed during the onsite, and staff were unable to describe the difference between routine care and health maintenance/preventive care. Staff also confirmed this is not a standard that is monitored. Also, the policy does not address the requirement from the *SCDHHS Contract, Section 6.2.2.3.5*, that "Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures." *Quality Improvement Plan: Revise Policy MCD-11 to remove the appointment standard for Health Maintenance and Preventative Care. Include information that walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.*	✓	
MEMBER SERVICES			

Standards	Healthy Blue 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
2. The MCO applies grievance policies and procedures as formulated.	Policy SC_GAXX 015, Grievance and Appeals for Members, indicates that a written acknowledgement of the member's grievance is sent within 5 calendar days of receipt of the grievance. CCME reviewed a sample of grievance files and found that three of the files did not meet Healthy Blue's Policy SC_GAXX-015 for sending a written acknowledgement within five calendar days. *Quality Improvement Plan: Conduct an internal audit of files to ascertain compliance with Healthy Blue's grievance policy. Address any deficiencies with staff to determine interventions needed to improve performance.*	✓	
UTILIZATION MANAGEMENT			
6. Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	The Pharmacy Program Description explains that IngenioRx is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities. Healthy Blue'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. It was not clear when the changes were posted to the website. Page 10 of the Pharmacy Program Description indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the *SCDHHS Contract* requires the change be published on the website at least 30 days prior to implementation. *Quality Improvement Plan: Update the PDL change document posted on the website and include the date the change document was posted. Also, update the Pharmacy Program Description to indicate that changes are published on the website at least 30 days prior to implementation as required by the SCDHHS Contract, Section 4.2.21.2.1 and 4.2.21.3.*	✓	
2. The MCO applies the appeal policies and procedures as formulated.	CCME's review of appeal files concluded that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. The following are issues identified with the appeal files: •Healthy Blue's Policy SC_GAXX_051, Member Appeal Process, indicates the member or authorized representative is mailed a copy of the case file, within 10 calendar days of receipt of the appeal. There were nine files where the case file was not sent within the 10-day timeframe or was not sent at all. <u>This was an issue identified during the 2021 EQR.</u>	✓	

Standards	Healthy Blue 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	•Three files required the member to submit the appeal request in writing after requesting the appeal orally, even though this is no longer a requirement. •The physician who made the appeal decision for three files was not the same or similar specialty as the requesting provider. *Quality Improvement Plan: Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy, SCDHHS Contract, and federal regulations. Implement interventions to address the barriers.*		
DELEGATION			
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Documentation was submitted for all delegated entities showing annual and/or pre-delegation assessment conducted in the last year. The documentation shows recommendations and corrective actions were implemented with the delegates when appropriate. For credentialing delegates, the file review worksheets do not provide evidence that the delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges. *Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for compliance with initial credentialing timeframe requirements and for ensuring applicable providers have admitting privileges or an admitting arrangement. These elements should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.*	✓	
STATE MANDATED			
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10-day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process. *Quality Improvement Plan: Implement Quality Improvement Plans from the EQR to address all identified deficiencies.*	✓	

Humana Healthy Horizons 2023 Quality Improvement Plan

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	Humana's general approach to policies and procedures has been revised as a result of the Quality Improvement Plan for the 2022 EQR. The 2023 EQR and corresponding onsite discussion confirmed that Humana implemented a policy review cycle and consolidated and updated many policies. The health plan's process includes review of policies and procedures by the policy's Business Owner and Regulatory Compliance staff to ensure an annual review cycle. Information about policy changes is shared with staff by leadership from each department, and staff may access policies via Humana's Enterprise Solution Point system. Despite these changes, CCME noted continued issues with health plan policies, including: • Humana provided several versions of its Policy Index. The first index provided listed approximately 156 policies and the second index listed approximately 175 policies. During the onsite visit, some policies were referenced or discussed that were not listed on the Policy Index. The final policy index submitted for review included policies that did not specify a policy number and/or business owner. • Some policies were provided in a draft format. Examples include Policy QM-288-08, Provider Quality Review Process (draft watermark with a last review date of 1/27/22); Enterprise-Wide Policy #5051331 – Procedure - Government Programs PCP Request for Member Transfer DRAFT (draft watermark with a last review date of 9/8/22); and Policy (Preauthorization List (PAL) Governance)-001 (draft watermark with issue date of 2/25/22). • Some policies did not provide a policy number within the document, although the document file name listed a number. Examples include the document labeled as "SC.MCC.008," "SC.CDT.001," and "SC.FIN.003." *Quality Improvement Plan:* • *Revise the Policy Index to include all policies followed for conducting health plan activities and functions within SC.* • *Update the Policy Index to provide a policy number and business owner for each policy listed.* • *Ensure all policies include an identifying policy number within the policy.* • *Ensure policies are not left in a draft format once the routine review cycle is complete and the policy is approved.*	✓	

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	• *Consider adding the most recent policy review date for each policy listed on the Policy Index.*		
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));	The *SCDHHS Contract, Section 2* requires that the "Contractor have a full-time administrator with clear authority over general administration and implementation of requirements set forth in the contract, including responsibility to oversee the budget and accounting systems implemented by the CONTRACTOR, and have the authority to direct and prioritize work, regardless of where performed." Due to discrepancies in the information provided by health plan documentation, reported during the onsite visit, and provided to SCDHHS, it is unclear who fulfills the requirements of the *SCDHHS Contract, Section 2* for the key position of Administrator (CEO, COO, Executive Director, etc.). • The Organizational Chart lists Natalia Aresu as the South Carolina CEO Market Leader. • Humana reported to SCDHHS that Ms. Aresu is the Chief Executive Officer. • The "Staffing List 3.23" lists Ms. Aresu as "VP, Medicaid Regional President." • Humana's Organizational Chart lists Kim McElroy as Humana's Director, Market Leadership, and it was confirmed that she is located in South Carolina. However, Ms. McElroy was reported to be the Chief Operating Officer during the onsite visit. • Ms. McElroy was not included in the Key Personnel list reported to SCDHHS. *Quality Improvement Plan: Clearly identify the individual who fulfills the role required by the SCDHHS Contract, Section 2 for a health plan Administrator (CEO, COO, Executive Director, etc.) located within the state of South Carolina.*	✓	
1.7 *Provider Services Manager;	The *SCDHHS Contract, Section 2* requires a "Provider Service Manager to coordinate communications between the CONTRACTOR and its Subcontracted Providers. There shall be sufficient Provider services staff to enable Providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the Managed Care Program and maintain a sufficient Provider network." The *SCDHHS Contract* requires the Provider Services Manager to be located within SC. Because of discrepancies in the information provided by health plan documentation, reported during the onsite visit, and provided to SCDHHS, it is unclear who fulfills the requirements of the *SCDHHS Contract, Section 2* for the key position of Provider Services Manager. • Humana reported to SCDHHS that Cynthia Forcade is the Provider Services Manager. • The Key Personnel List provided by Humana indicates Gina Ruiz is the Provider Services Manager.	✓	

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	• Per onsite discussion and the "Staffing List 3.23" document provided after the onsite visit, Cynthia Forcade is the Director of Contracting and Gina Ruiz is the Provider Contracting Executive. • There is no Provider Services Manager listed on the "Staffing List 3.23" document." *Quality Improvement Plan: Clearly identify the individual who fulfills the role required by the SCDHHS Contract, Section 2 for a Provider Services Manager located within the state of SC.*		
1.8 *Member Services Manager;	The *SCDHHS Contract, Section 2* requires a "Member Services Manager who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times; and assist members when necessary to access culturally competent, high quality integrated medical and Behavioral Health care." Taffney Hooks is listed as Humana's Member Services Manager on the SC Medicaid Key Personnel List submitted prior to the onsite visit. However, the Administration tab of the "Staffing List 3.23" document provided after the onsite visit indicates Ms. Hooks' role as Compliance Lead, and the Member Services tab does not specify anyone in the role of Member Services Manager. The *SCDHHS Contract, Section 2,* requires 1 Full Time Employee for both the Member Services Manager position and the Contract Account Manager position. Ms. Hooks is serving in both roles. *Quality Improvement Plan: Hire a full time Member Services Manager located in SC.*		✓
2. Operational relationships of MCO staff are clearly delineated.	The Organizational Chart provided by Humana does not display the operational relationships for key areas such as Member Services, Provider Services, Grievances and Appeals, Network Management, etc. Operational relationships of staff are also not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists. *Quality Improvement Plan: Revise the Organizational Chart to denote all key staff and their location. Revise the Organizational Chart to display the reporting structure for all staff/departments. Staffing Lists and Key Personnel Lists should be consistent with the Organizational Chart and include staff credentials and location.*	✓	
PROVIDER SERVICES			

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
2. The MCO maintains a provider directory that includes all requirements.	The online "Find a Doctor" tool displays all required Provider Directory elements. Each of the PDF versions of the Provider Directories included the following statements, which appear to be contradictory: • Page 8 states, "To find out which providers are not taking new patients, go to Humana's website or call Member Services." • Page 13 states, "Provider information is current as of the date listed on the cover. Below are the types of provider information you will find."…"Whether the provider is accepting new patients." The PDF versions of the regional Provider Directories submitted by Humana do not include an indication of providers that are not accepting new patients. This is a requirement of both the *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR 438.10 (h) (1) (vi)*. *Quality Improvement Plan: To comply with requirements of the SCDHHS Contract, Section 3.13.5.1.1, and 42 CFR 438.10 (h) (1) (vi), revise the PDF Provider Directories to include an indicator of any providers who are not accepting new patients.*	✓	
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	Policy SC.NNO.007, Provider Orientation and Annual Training, provides an overview of the process for conducting new provider orientation; however, it is not specific to SC. An example is the statement, "When a new provider orientation is required and/or necessary (based on type of plan), or the provider has requested orientation, the contractor will initiate the orientation process as follows, normally within thirty (30) days of the date of the executed contract." Also, the policy states the Contractor "Conducts orientation covering the appropriate issues outlined on the New Provider Orientation Training and/or Checklist, (Resource A) and any other market specific requirements." Section VIII (Resources) of the policy lists two documents, including Sample New Provider Orientation Checklist Market and South Carolina Medicaid Annual Training Requirements. In response to CCME's request for a copy of the New Provider Orientation Checklist used for South Carolina providers, Humana stated the SC plan does not "utilize a new provider orientation checklist for SC Medicaid new provider orientation. The referenced policy SC.NNO.007 is generic to all markets and all lines of business. We follow the state-specific guidelines for SC Medicaid that are referenced in the policy." This statement is confusing as this policy is labeled as a South Carolina policy per the policy number of SC.NNO.007. Also, the reference in the policy to the New Provider Orientation Checklist was an issue noted during the previous EQR. Humana staff explained the initial provider orientation process and stated that an initial welcome letter is sent followed by a welcome call within 30 days. Humana provides links to all provider resources and offers one-on-one training if the provider desires.	✓	

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	CCME reviewed the Healthcare Provider Resource Guide, which provides information about online self-service, online resources, the Availity Portal, claims, prior authorization information, and contact information. The 2022 Provider Manual and the health plan's website are additional resources for providers. *Quality Improvement Plan: Revise Policy SC.NNO.007, Provider Orientation and Annual Training, to clearly document processes for initial provider education for the South Carolina market.*		
2. Initial provider education includes: 2.10 Reassignment of a member to another PCP;	CCME did not identify information in the Provider Manual regarding reassignment of a member to a different PCP. This was discussed during the onsite and Humana staff were unable to provide a clear explanation of any circumstances under which a PCP can request reassignment of a member to another PCP. After the onsite, Humana provided the following response: "Humana Healthy Horizons in South Carolina follows the procedures outlined in our Enterprise-Wide Policy #5051331-Procedure- Government Programs PCP Request for Member Transfer. This policy was last reviewed on September 8, 2022. HHH in SC continues to work diligently to streamline our policies and procedures. Humana Healthy Horizons in South Carolina will develop a SC Medicaid specific policy regarding PCP request for member transfer." *Quality Improvement Plan: Develop a South Carolina market policy to define the requirements and process for a PCP to request reassignment of a member to a different PCP. Include information about circumstances under which a provider may request transfer of a member to another PCP in the Provider Manual.*	✓	
MEMBER SERVICES			
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	Policy SC.MCC.008, Disenrollment, outlines steps taken by Customer Care Advocates (CCAs) when a member verbalizes a wish to disenroll from the health plan. The policy states that the Customer Care Advocate will "offer or attempt to resolve any of the members' reasons for dissatisfaction and appropriately log any issues as a grievance." The policy continues to state that "CCA will determine if the member previously filed a grievance about their request to disenroll. If a grievance was not previously filed, CCA will document the reason the member wants to disenroll and advise the member that a grievance must be filed to disenroll from the plan." The *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5* address requirements for member disenrollment requests both with and without cause. There is no contractual requirement that members must file a grievance with the health plan in order to request disenrollment.	✓	

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	Quality Improvement Plan: Revise Policy SC.MCC.008 and internal processes to remove the requirement that a member must file a grievance in order to request disenrollment.		
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.1 The definition of a grievance and who may file a grievance;	Policy SC.GAA.001 and page 10 of the Member Handbook define a grievance as, "an expression of dissatisfaction about any matter other than an Action." The term "action" is outdated, and the correct term is "adverse benefit determination." Refer to the *SCDHHS Contract, Section 9* and *42 CFR 438.400 (b)*. It was noted that page 63 of the Member Handbook uses appropriate verbiage when defining a grievance. Humana's website defines a grievance as, "a formal complaint or dispute expressing dissatisfaction with any aspect of the operations, activities or behavior of Humana or its providers." As written, this definition is incomplete, as it omits the language "other than an adverse benefit determination." The term "grievance" is correctly defined on page 33 of the Provider Manual. Policy SC.GAA.001, the Member Handbook, and the Provider Manual correctly describe who can file a grievance and state a grievance can be filed at any time. *Quality Improvement Plan: Correct the definition of a grievance in Policy SC.GAA.001, the Member Handbook (page 10), and on Humana's website.*	✓	
QUALITY IMPROVEMENT			
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.	Humana submitted the 2022 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description. This program description provides an overview of the QI program Humana has in place to monitor, evaluate, and facilitate improvement in the quality of health care services provided to members. The program's goals, scope, and methodologies are included. The program description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships). Humana addressed this during the onsite and indicated there were currently five staff assigned to the QI Program as well as the Medical Director's involvement. The organizational chart for the Quality Department was provided after the onsite. *Quality Improvement: Update the QI Program Description and include the program's structure related to the staff assigned to the QI Program and their responsibilities.*	✓	

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
2. The composition of the QI Committee reflects the membership required by the contract.	The SC Medicaid Medical Director serves as the chair for the QAC. Per the committee charter, voting members include various members of Humana's Management Team and participating network providers. Non-voting members include other staff representing additional business areas of the organization. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. However, the committee minutes for meetings held in 2022 did not include any participating network practitioners. The minutes for the meeting held in January 2023 documented one network practitioner and one physician consultant not participating in Humana's network had been added. This was an issue identified during the previous EQR and not corrected. *Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.*		✓
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	Annually, Humana completes an evaluation of the previous year's QI Program to determine the effectiveness of the program. Humana provided the 2021 – 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation for review. The QI Program Evaluation included the outcomes of some of the activities completed or underway during 2021 and 2022. A barrier analysis and recommendations for 2023 to overcome those barriers were also included. The evaluation lacked the results and analysis for the following activities: • Timely Access/PCP Wait Times • Network Adequacy (time and distance) • The Utilization Management Overview Data (Over and Underutilization) • Delegation Oversight monitoring Also, the goal for measuring the credentialing and recredentialing activities appeared to be incorrect. The goal listed in the background information indicated the goal for completing the credentialing process is 30 days. The results table listed the goal as 90 days and the goal noted in the 2022 QI work plan was listed as 60 days. The graph on page 20 of the QI Program Evaluation only included the results of the recredentialing activities. These deficiencies were discussed during the onsite. Staff explained the QI Program Evaluation was created for accreditation purposes and did not contain 12 months of data. *Quality Improvement Plan: Correct the errors in the QI Program Evaluation and include the results of all activities completed and/or an update for the ongoing activities.*		✓
UTILIZATION MANAGEMENT			

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	Humana provided the Utilization Management (UM) Program Description 2023 for review. This Program Description outlines the staff responsibilities, scope, and objectives for physical and behavioral health services. Page five of the UM Program Description indicates the Quality Assessment Committee provides monitoring, oversight, and direction of the UM Program. During the onsite, staff indicated the committee responsible for oversight of the UM Program is the Quality Assurance Committee. This was identified in the 2022 UM Program Description during the 2022 EQR. CCME recommended Humana correct the UM Program Description; however, that change was not made in the 2023 UM Program Description. The Pharmacy Program is integrated into the UM Program. According to the 2023 Pharmacy Program Description, Humana Pharmacy Solutions is the pharmacy benefit manager. However, page 15 of the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager. *Quality Improvement Plan: Correct the deficiencies in the UM Program Description and remove the references to the Quality Assessment Committee. Also, verify the pharmacy benefit manager for SC and correct the UM Program Description, Pharmacy Program Description, and/or Humana's website.*	✓	
1.3 guidelines / standards to be used in making utilization management decisions;	Per the UM Program Description, Utilization Management decisions are made using established UM criteria. Criteria are evaluated and approved on an annual basis. All review decisions are based on the information collected at the time of the request. Humana maintains a list of services that require prior authorization. Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provide an overview of how these lists are established, maintained, and updated. During the 2022 EQR, CCME noted both policies contained basically the same information and were watermarked as "draft." No explanation was provided regarding the purpose of both policies. A recommendation was made to review both policies to determine which policy best defines the process Humana uses to manage the preauthorization list. For this EQR, Humana did not provide these policies with the desk materials. CCME questioned staff during the onsite and the staff indicated the policies were still active. Copies were provided. The copies provided were still labeled as draft and contained tracked changes. *Quality Improvement Plan: Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002, finalize the tracked changes, and remove the draft watermark.*	✓	

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
6. Pharmacy Requirements 6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	Processes for medication prior authorization requests are discussed in the Pharmacy Program Description, which mentions providers receive a determination notification within 24 hours of a request for prior authorization. The *SCDHHS Contract, Section 4.2.21.3.2,* requires the health plan to authorize a 72-hour emergency supply of medications to members in emergent situations until a decision is received. There was no mention of the process used to meet this requirement in the Pharmacy Program Description, the Member Handbook, Provider Manual, or in a policy. During onsite discussion, the health plan was able to describe the process when an emergency supply is needed; however, this process is not documented. *Quality Improvement Plan: Develop a policy and include in the Pharmacy Program Description the process followed to authorize a 72-hour supply of medications to the members in emergent situations, as required by the SCDHHS Contract, Section 4.2.21.3.2.*	✓	
2. The MCO applies the appeal policies and procedures as formulated.	Humana provided a sample of appeal files for review. The following issues were identified in the files: • The resolution notices for five files indicated the decision was made by a specialist in the Grievance and Appeal Department or by a medical director. However, the decisions were made by a consultant with the Network Medial Review Company. • The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. The resolution letters included references to medical literature and medical terminology such as "tardive dyskinesia," "neuroendocrine tumors," and "hypereosinophilic syndrome." These were the same issues identified during the 2022 EQR. Also, three expedited appeal requests were not resolved within the 72-hour timeframe. In two of the files, it appeared the physician reviewer used a KY administrative code and a KY fee schedule for making the determination. *Quality Improvement Plan: Develop a process for monitoring resolution notices to ensure the letters contain correct reviewer information and meet the SCDHHS 6th grade reading level requirement (SCDHHS Contract, Section 3.15.12 and 42 CFR § 438.10). Also, monitor timeliness for completing expedited appeals and remind reviewers that other state administrative codes and fee schedules should not be used for making determinations.*	✓	
STATE MANDATED			

Standards	Humana Healthy Horizons 2023 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	During the previous EQR, there were 16 standards scored as "Partially Met" and 8 standards that received a "Not Met" score. Following the 2022 EQR, Humana submitted a Quality Improvement Plan to address the deficiencies. CCME reviewed and accepted the Quality Improvement Plan on June 28, 2022. During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plans were not implemented for the deficiencies related to: • References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana has confirmed in both 2022 and 2023 that this checklist is not used. • Lack of a variety of participating network providers as members of the committee responsible for the Quality Improvement activities. Humana's Quality Assurance Committee did not contain a variety of participating network providers. For this EQR, one network practitioner and one physician consultant not participating in Humana's network had been added. • Several appeal resolution letters did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letters stated, "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." Additionally, in several appeal resolution letters the verbiage used to describe why the denial was upheld appeared to be above the 6th grade reading level. *Quality Improvement Plan: Develop a plan of action to address and correct the deficiencies identified during this and previous EQRs. Include a monitoring component to ensure the plans are implemented timely and all deficiencies are corrected.*		✓

Molina 2022 Quality Improvement Plan

Standards	Molina 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 43% of the time (51 out of 105) when omitting 13 calls answered by personal or general voicemail messaging services. This is a statistically significant decline from last year's rate of 63%. For calls not answered successfully (n= 54 out of 105 calls), the majority (n = 40, 74%) were because the physician was no longer practicing at the location. *Quality Improvement Plan: Provide documentation of specific processes in development or recently initiated to improve accuracy of provider contact information and status/location.*	✓	
QUALITY IMPROVEMENT			
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	Molina evaluates the overall effectiveness of the QI Program and reports this assessment to the Board of Directors and the QIC. The Quality Improvement Program 2020 Medicaid Annual Evaluation was provided. The program evaluation included the Executive Summary and several appendices. Most of the results of the activities conducted in 2019 were included in the program evaluation. Activities related to the availability of practitioners (section 5.0 of the work plan), the continuity and coordination of care (section 9.0 and 10 of the work plan), and the provider directory analysis (section 11 of the work plan) were not included. The section in the Executive Summary regarding the focus for the upcoming year incorrectly included the focus for 2022 instead of 2021. These errors and omissions were discussed during the onsite. Molina indicated those activities omitted from the program evaluation were conducted and provided copies of some of the reports after the onsite. However, these activities were not considered when the 2020 QI Program Evaluation was conducted. *Quality Improvement Plan: When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.*	✓	
UTILIZATION MANAGEMENT			

Standards	Molina 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Molina'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 those changes were approved by the Pharmacy and Therapeutics Committee and 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. Molina'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 Molina's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*	✓	
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	Requirements for filing an appeal are documented in policies and procedures. Policy and procedure MHSC-MRT-002, Standard Appeal Process, the UM Program Description, the Guidelines for Appealing a Medical Denial, the Member Handbook, the Provider Manual, and the website indicate a standard request for an appeal received verbally must be followed by a written request within 30 days. This requirement was removed from the *SCDHHS Contract* and the *Federal Regulation*. *Quality Improvement Plan: Revise all documents related to the process for filing an appeal and remove the requirement that indicates a standard request for an appeal received verbally must be followed by a written request.*		✓
2. The MCO applies the appeal policies and procedures as formulated.	A sample of appeal files were reviewed. There were three files that were untimely and four files where the physician who made the appeal decision was not of the same or similar specialty as the ordering physician. Two of those cases were pediatric cases reviewed by a physician who specializes in internal medicine and two plastic surgery cases also reviewed by a physician who specializes in internal medicine. According to staff, the physicians' reviewing appeal requests are directed to use criteria and matching specialty was not necessary. Molina was cautioned regarding allowing physician reviewers to only utilize criteria when making medical necessity decisions on appeals. *Quality Improvement Plan: For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate physician reviewers regarding only utilizing review criteria and not considering individual medical conditions when making appeal determinations.*	✓	

SC Solutions 2022 Quality Improvement Plan

Standards	Solutions 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
3. Employee personnel files demonstrate compliance with contract and policy requirements.	CCME reviewed a sample of personnel files and found the initial exclusion screenings had been conducted. However, the files lacked evidence of the monthly exclusion monitoring as required by Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks. Solutions provided additional screenshots of monthly queries to demonstrate the exclusion screenings were conducted. For the review period (June 2021 through May 2022) none of the files contained 12 months of screenings. *Quality Improvement Plan: Review processes needed to ensure that steps are taken to complete monthly exclusion monitoring to align with Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting.*	✓	
CARE COORDINATION/CASE MANAGEMET			
2.10 Processes for following up with participants admitted to the hospital and actively participate in discharge planning.	Policy and Procedure CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment, only addresses discharge from Solutions and from the MCCW program. A policy addressing discharge planning for participants who are admitted to a hospital was not found. Solutions staff confirmed a policy has not been created for this topic, but stated Care Coordination staff are encouraged to access the electronic health record systems to which they have access (Prisma and MUSC) for discharge summaries, etc. Staff also stated Care Coordination staff work hospital care management staff to ensure discharge needs are met. *Quality Improvement Plan: Develop and implement a policy and procedure that details the roles and responsibilities of Care Coordination staff in discharge planning processes for currently enrolled participants who are admitted to a hospital.*	✓	
2.11 Processes for reporting suspected abuse, neglect, or exploitation of a participant.	Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, states Care Coordinators review Child Protective Services information with the responsible party during the Pre-Admission Screening visit. Responsible parties are informed that Care Coordinators and other staff are required to report any signs of/suspected abuse or neglect to the Department of Social Services. This policy details how staff enter information into the Phoenix system but does not provide detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant or actions taken after filing a report. *Quality Improvement Plan: Revise Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, to include detailed information about the process for reporting*	✓	

Standards	Solutions 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	suspected abuse, neglect, or exploitation of a participant, and any actions taken/follow-up after a report is made.		

Select Health 2022 Quality Improvement Plan

Standards	Select Health 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
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 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.*	✓	

Standards	Select Health 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
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.*	✓	
UTILIZATION MANAGEMENT			
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 onsite discussion, 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 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. *Quality Improvement Plan: Update the Provider Manual to reflect that an acknowledgement letter is sent within 5 business days to align 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.*	✓	

Standards	Select Health 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
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 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. 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 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.*	✓	

Molina Medicare/Medicaid Plan 2022 Quality Improvement Plan

Standards	Molina Medicare/Medicaid Plan 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
CARE TRANSITIONS			

Standards	Molina Medicare/Medicaid Plan 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	Care transition processes and staff activities are described in Policy MHSC-HCS-CM-068-MMP, Molina Transitions of Care, and the associated procedure. Molina's Transition of Care (TOC) Program is applicable to any members with transitions to and from home, hospitals, skilled nursing, rehabilitation, inpatient psychiatric care, etc. The role of TOC Coaches is to assist with coordination of care activities throughout the transition period to ensure aftercare is scheduled, services and supports are in place, and transition needs are met. A review of a sample of TOC files revealed the following: •Some calls were documented to check on the member's inpatient status, but very few instances of collaboration with facility Case Management or Discharge Planning staff to ensure safe transition were documented. •Primary care provider (PCP) notifications of admission and discharge were inconsistent. Some files had no documentation of notification, while others stated the PCP could not be notified due to no PCP on file, etc. Some files indicated the TOC/CM staff would work to engage the member with a PCP, but no further action was documented. •Documentation of identified needed clinical and non-clinical supports, transition/aftercare appointments, and barriers to after-care was lacking in most files. •Some files had no documented attempts to contact the member to conduct the 72-hour follow-up post discharge. However, some files did include documented attempts to conduct the 72-hour follow-up, but many of the first attempts were outside of the 72-hour window. •Few files included documentation of post-discharge assessments. Molina documented that some of the members could not be contacted, but for others, there was no explanation included in the file. These findings were discussed with Molina during the onsite visit, and Molina explained issues they had identified, and actions taken to resolve the identified issues. *Quality Improvement Plan: Review existing processes and make necessary changes to ensure TOC files reflect clear documentation of all activities required by the CICO 3-Way Contract, Section 2.5 and 2.6. All files should include documentation of:* *•Collaboration with facility Case Management/Discharge Planning staff.* *•PCP notification of each admission and discharge.* *•Activities undertaken to engage members with a PCP when no PCP is on file.* *•Identified clinical and non-clinical supports needed, transition/aftercare appointments, and barriers to after-care,*		✓

Standards	Molina Medicare/Medicaid Plan 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	•Attempts to contact the member to conduct the 72-hour follow-up within 72 hours of the member's discharge, and *•Attempts to conduct post-discharge assessments for any of the trigger events noted in the CICO 3-Way Contract, Section 2.6.3.9.4.*		

First Choice VIP Care Plus by Select Health of SC 2022 Quality Improvement Plan

Standards	First Choice VIP Care Plus by Select Health of SC 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
CARE TRANSITIONS			
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	CCME reviewed a sample of 30-day readmission files submitted by Select Health. Overall, the file review indicated staff consistently attempted to conduct the required follow-up within 72 hours of discharge. When unable to contact members throughout the transition period, staff attempted to obtain alternate contact information from other sources, such as home health agencies, PCPs, and pharmacies involved in the member's care. There were issues noted in the reviewed files, including: •Some files reflected no attempts to contact the facility's Case Management/Discharge Planning staff to collaborate in discharge planning. However, page three of Policy CM 156.209 states, "Upon receipt of an authorization request at the time of admission, the Care Coordinator is alerted and contacts the discharge planner by the end of the following business day to obtain admission information, treatment plan, enrollee status, and to initiate discharge/transition planning." •Some files did not provide evidence of any collaboration with the PCP when the member admitted or discharged. Page four of Policy CM 156.209 states, "The Care Coordinator (or designee) will request a copy of discharge instructions, or other transition plans and ascertain whether these transition plans were sent to the PCP. 1. The Care Coordinator (or designee) will submit all discharge instructions and transition plans via fax to the PCP or treating provider." •Some files did not provide evidence of reassessments following a trigger event or an explanation for why one was not done. Page four of Policy CM 156.209 addresses the phone call or home visit conducted by the Care Coordinator (or designee) within 72 hours of transition and		✓

Standards	First Choice VIP Care Plus by Select Health of SC 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	states, "A reassessment of the Enrollee's condition and needs will be completed during this contact." This is a repeat finding from the previous EQR. *Quality Improvement Plan: Ensure all contractual transition of care requirements are met and staff comply with processes documented in Policy CM 156.209, Comprehensive Transitional Care.*		

Wellcare Prime by Absolute Total Care 2022 Quality Improvement Plan

Standards	Wellcare Prime by Absolute Total Care 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
CARE TRANSITIONS			
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	The Healthy Connections Prime Care Management Program Description 2022 defines the program's purpose, scope, goals and objectives, and structure, and describes Care Management processes. CCME reviewed a sample of care transitions files for 35 members who were noted to have a readmission for specific diagnoses within 30 days of a previous discharge. Overall, the files reflected good documentation of supports needed by members after discharge, as well as barriers and interventions to address those barriers. The files also reflected attempts to obtain alternate contact information for members who were difficult to reach, letters to members notifying them of unsuccessful outreach attempts, and documentation of medication reconciliations. Issues noted in the files included: •Untimely attempts to contact members/caregivers within 72-hours of discharge for eight member files. •Lack of documentation of interaction with facility Case Managers or Discharge Planners was noted for six files. •Lack of documentation of collaboration with the PCP was noted for three files.		✓

Standards	Wellcare Prime by Absolute Total Care 2022 EQR Findings	2023 EQR Findings	
		Corrected	Not Corrected
	Quality Improvement Plan: Ensure files include thorough and complete documentation of all required activities, including collaboration with facility Case Managers or Discharge Planners, collaboration with the PCP, and post-discharge TOC assessment within 72-hours of discharge.		