Constellation Quality Health

Healthy Blue by BlueChoice Health Plan of South Carolina

2023 Readiness Review

Submitted: November 8, 2023

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the Readiness Review that Constellation Quality Health, formerly The Carolinas Center for Medical Excellence (CCME), conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

This review was to assess the preparedness of Healthy Blue by BlueChoice Health Plan of South Carolina (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.

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.

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 Healthy Blue'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 five areas. A high-level summary of the review results for those areas follows. The Availability of Services *(§ 438.206, § 457.1230*), Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230*), Provider Selection *(§ 438.214, § 457.1233), and* Practice Guidelines *(§ 438.236, § 457.1233)* were not included in this Readiness Review. Those areas were assessed during Healthy Blue's 2023 Annual EQR conducted by Constellation Quality Health in July 2023.

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. Although Policy MCD-CP 15, Policy Development, Review, and Management, states policies will be reviewed and approved by the Compliance Committee, onsite discussion confirmed policy approval will be given by the Policy Committee and reported to the Compliance Committee. A defined format has been developed for policies and procedures. Staff will be educated about new and revised policies by departmental leadership and a bi-monthly compliance newsletter, and staff can access policies on a shared drive and on the policy management platform.

Review of the Organizational Chart and corresponding onsite discussion confirmed that all key positions are filled, and staffing projections appear to be adequate. All vacant positions have either been filled or recruitment activities are in progress.

Healthy Blue's written Compliance Plan is scheduled for review and approval by the Compliance Committee in November 2023. The Compliance Plan describes processes for ensuring compliance with laws, regulations, and contractual and accreditation standards. Attachments to the Compliance Plan include the Compliance and Program Integrity Organizational Chart, the Compliance Committee Membership List, the Delegated Vendor Management and Oversight Policy, and the Healthy Blue Antifraud Plan. The Antifraud Plan

addresses activities related to identifying, detecting, and preventing FWA. In addition, related policies and procedures were submitted that addressed topics including, but not limited to privacy, confidentiality, fraud, waste, and abuse (FWA), the False Claims Act, and related reporting.

The Compliance Officer reports to the Chief Executive Officer, chairs the Compliance Committee, and oversees all compliance activities. The Program Integrity Coordinator works with the Special Investigations Unit to coordinate FWA activities with the SCDHHS Division of Program Integrity. The Compliance Committee reports through the Managed Care Oversight Committee to the Board of Directors. Healthy Blue's new Compliance Committee will commence operations in November 2023 and will meet at least monthly and as needed. The committee quorum is defined as the presence of 50% of the voting members.

The Compliance Plan along with the 2023 Compliance Overview and Our Values (code of conduct) address expectations for ethical business conduct. The documents address topics including but not limited to laws and regulations related to FWA, reporting responsibilities for compliance and FWA concerns, avenues and contact information for reporting concerns, etc. All staff must complete new employment and annual compliance training. Additional training is provided for reassignments of job functions, changes in guidelines, etc. 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.

Healthy Blue's Pharmacy Lock-in Program meets all contractual requirements and will be overseen by the pharmacy benefit manager.

Policy MCD-CP 12, Privacy and Confidentiality, provides detailed and comprehensive information about processes Healthy Blue has implemented to ensure member privacy and the confidentiality of protected health information.

Healthy Blue's documentation indicates the MCO's information systems, policies, and procedures are able to meet the State's contract requirements. The organization adheres to best practices in monitoring and responding to potential security issues. Additionally, the organization performs regular audits to validate the performance of its system controls. The audit results provided show the organization has the necessary measures to protect data and control access. No outstanding issues were found in the audits and the results helped the organization identify possible improvements or efficiencies that could be implemented. Finally, Healthy Blue has been efficient in regularly reviewing documentation and keeping it up to date.

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 are listed in Policy MCD-CST 18, Member Rights and Responsibilities. Members are informed of their rights and responsibilities in the Member Handbook, and the rights are also listed in the Provider Manual. Processes were discussed onsite specific to materials submitted for review, indicating that this information 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 and Nurse line.

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 Nurseline. Members are informed of changes to benefits in writing thirty days prior to any changes. Printed material or verbal assistance is made available to members in languages other than English as needed. The Member Handbook and Provider Manual provides information on advance directives and on reporting suspected fraud, waste, and abuse.

Steps for primary care provider (PCP) selection are outlined in the Member Handbook and on the website. Assistance is available by contacting Customer Services. 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 included in the Member Handbook and the 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 the CAHPS surveys. The policy notes that the plan will use SPH Analytics (now Press Ganey), an accredited vendor, for the survey administration. The policy mentions that "actions will be implemented to address the opportunities for improvement." However, the policy does not specify which department or committee will be the primary party responsible for developing and tracking the action steps. The analysis and implementation of interventions to improve member satisfaction are discussed during the appropriate internal committee meetings.

The receipt and processing of member grievances are described in Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual. Issues were identified regarding the timeframes for acknowledging a grievance, 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 resolution timeframe, and providing the member with prompt oral notification if an extension is requested.

Quality Improvement

42CFR §438.330, 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 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.

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. There was no mention in this policy of including 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 is also not included in the policy. There was no documentation of the action steps that will be taken if over or underutilization are identified. The policy states, "interventions are identified for implementation", however, there is no information on how this occurs or 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 specific timeframes for completion of each activity. A sample QI work plan was provided. Healthy Blue views this work plan as a dynamic document and updates the document frequently.

The Clinical Quality Improvement Committee has been established as 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.

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. The gaps in care reports assist the providers in identifying members who have not completed their annual care. Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, discusses the review, adoption, and dissemination of the preventive and clinical practice guidelines. However, this policy does not address monitoring to ensure providers adhere to these guidelines.

At least annually, Healthy Blue will formally conduct an evaluation of the QI Program. The evaluation 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.

For the performance measure and performance improvement project validation, Constellation Quality Health reviewed Healthy Blue's plan for how HEDIS measures will be collected and reported and how projects with be determined and documented.

Performance Measure Validation - There were two policies submitted related to 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 policy which 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 - 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, utilization data, or other system data may be included as part of the 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 be used for documenting the performance improvement projects. 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, as well as 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, as well as a place for statistical significance testing, when sampling is applied.

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)

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. CarelonRx serves as Healthy Blue's pharmacy benefit manager.

Healthy Blue's 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 perform initial clinical determinations. Second level reviews are conducted by licensed physicians with similar specialties. Healthy Blue described the internal and external guidelines that are utilized to perform clinical determinations. However, the guidelines and standards were not outlined in policy or in the Program Descriptions. Supervision, training, and Preceptors, who serve as Peer Team Leaders, are provided to UM Reviewers at hire and ongoing to ensure accountability and consistency in performing standard authorization reviews.

Healthy Blue's Preferred Provider Program is offered to providers based upon an established approval rate and is audited annually.

The processes and requirements for covering hysterectomies, sterilizations, and abortions are described in various policies and the forms are available online for members and providers. Also, the process and guidelines of emergency and post stabilization services are outlined in various policies and the Member Handbook.

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. Transitional case management is also offered to members to provide assistance to members when transitioning across healthcare settings, during disenrollment, or enrollment.

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. Details of these deficiencies are included in the Utilization Management section of this report.

In maintaining documentation and analyzing trends of appeals, quarterly appeal logs will be submitted to SCDHHS. Additionally, appeal quarterly reports are presented during the Service Quality Improvement Committee meetings for review and feedback.

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 this review, Healthy Blue reported twelve delegation agreements.

Prior to delegation, the Quality Management/Accreditation and Compliance departments are responsible for conducting pre-delegation assessments. This process requires the potential delegate to submit documentation supporting its ability to successfully perform the delegated functions and/or services, in accordance with applicable federal and *SCDHHS Contract* requirements. For this Readiness Review CarelonRx and National Imaging Associates (NIA) were subject to a pre-delegation assessment. Results of these assessments found both entities were in compliance with all requirements.

For the credentialing delegates, copies of the annual audits conducted for AnMed Health, HCA Physicians Services Group, Medical University of South Carolina, Prisma Health, Roper St. Francis Physician's Network, SC Department of Mental Health, Self Regional Healthcare, Spartanburg Health/Regional Health Plus, and VSP Vision Care were provided. The pre-delegation audit was provided for Tenet (HCS Physicians). The documentation confirmed annual oversight is conducted and any identified issues were documented.

Conclusions

Overall, Healthy Blue met all of the requirements in eight of the ten categories set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Healthy Blue's compliance scores specific to each of the preceding 11 Subpart D and QAPI standards.

Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section II C	2	2	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section II A	2	2	100%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	8	8	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	13	13	100%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	18	12	66.6%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	13	7	53.8%

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

As noted in the preceding table:

- Policies and other materials related to how grievances and appeals will be processed did not meet all the requirements.
- Areas related to the QI Program Description, performance measures, QI projects, and provider monitoring were areas that received "Partially Met" scores in the Quality Assessment and Performance Improvement Program.

Table 2: Scoring Overview, provides an overview of the scoring of the Readiness Review. For the Readiness Review, 120 out of 134 standards received a score of "Met." There were 14 standards scored as "Partially Met," and no standards received a "Not Met" score.

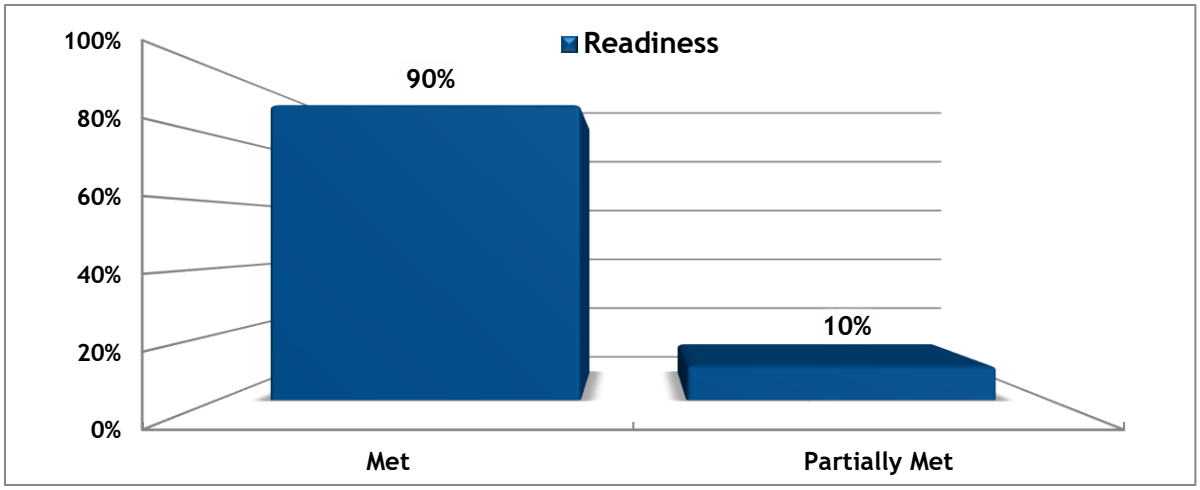
Table 2: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
Readiness Review	40	2	0	0	0	42	95%
Member Services							
Readiness Review	30	2	0	0	0	32	93.8%
Quality Improvement							
Readiness Review	7	6	0	0	0	13	53.8%
Utilization							
Readiness Review	41	4	0	0	0	45	91.1%
Delegation							
Readiness Review	2	0	0	0	0	2	100%
Totals							
Readiness Review	120	14	0	0	0	134	89.55%

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

The Readiness Review shows that Healthy Blue achieved "Met" scores for 90% of the standards reviewed as the following chart indicates.

Figure 1: Readiness Review Overall Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 3: Health Plan 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, and projected staffing appears to be adequate and meets contractual requirements.	✓		
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 fraud, waste, and abuse.	✓		
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.	✓		

Strengths	Quality	Timeliness	Access to Care
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 card 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.	✓		
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.			✓
Healthy Blue conducts scheduled Staff Review Check-Ins to assess any employee needs and provide supervision as needed.	✓		
Delegation			
Prior to delegation, the Quality Management/Accreditation and Compliance departments are responsible for conducting pre-delegation assessments. This process requires the potential delegate to submit documentation supporting its ability to successfully perform the delegated functions and/or services, in accordance with applicable federal and SCDHHS Contract requirements.			✓
Regular oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports.	✓		

Table 4: Weaknesses Recommendations and/or Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Administration				
Onsite discussion confirmed policies will be reviewed by the Policy Committee and reported to the Compliance Committee. However, Policy MCD-CP 15 states, "The Healthy Blue Compliance Committee is	Quality Improvement Plan: Revise Policy MCD-CP 15 to include the Policy Committee's role in policy review and approval.		✓	

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
responsible for … reviewing and approving all policies at least annually." It does not mention the Policy Committee's role in 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. The policy states, "Healthy Blue SC is expected to follow the timeline established by the SCDHHS Policy and Procedure Guide for member notification…"	Quality Improvement Plan: Revise Policy RX LOCK SC 43150, Lock-In SC Medicaid – Healthy Blue SC, to include the specific timeframe for notifying members of their inclusion in the lock-in program. As noted in the *SCDHHS Contract, Section 11.10.2.1,* the timeframe for member notification is no later than 30 calendar days prior to the effective lock-in date.			✓
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.	Recommendation: Include the responsible committee(s) that will initiate the interventions and monitor their progress for issues identified in the member satisfaction survey.	✓		
Policy MCD-CST 17, Member Grievances Process, and the Provider Manual indicate that grievances may be filed at any time verbally or in writing. However, the Member Handbook did not include the wording about the ability to file a grievance at any time.	Recommendation: 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.*	✓		
Policy MCD-CST 17, Member Grievances Process, states, "All Grievances have an acknowledgment letter sent within 7 days of receipt." The Provider Manual (page 94) 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."	Quality Improvement Plan: Correct the timeframe for acknowledging a grievance in the Provider Manual.		✓	
Timelines for the resolution of a grievances were accurately outlined in policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual. 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 also 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	Quality Improvement Plan: Correct Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and the Provider Manual to include the requirement to inform the member of the right to file a grievance if he or she disagrees with the 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.		✓	

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Member Handbook, and the Provider Manual does not include the requirement to inform the member of the right to file a grievance if he or she disagrees with the 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 (*SCDHHS Contract, Section 9.1.6.1.5.2*).				
Quality Management				
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.	Quality Improvement Plan: Update the QI Program Description to include other managers and staff supporting the QI program. Include the methodology to be used to implement the program, and correct the errors on page 12.	✓		
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.	Quality Improvement Plan: Policy MCD-UM 22 must be updated to include a comprehensive list of utilization measures of interest that will address the entire plan population and the plan service domains (inpatient, outpatient, pharmacy, emergency services). The determination of thresholds, including which department and wherein they are derived needs to be added to the policy. Finally, 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, as well as 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).	Quality Improvement Plan: 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.,	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
	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.	Quality Improvement Plan: 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 projects did not include all the elements that are required by the CMS protocol	Quality Improvement Plan: Develop a PIP template that aligns with the elements or requirements in the CMS protocol.	✓		
Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines discusses the review, adoption, and dissemination of preventive and clinical practice guidelines. However, this policy does not address the monitoring to ensure providers adhere to these guidelines.	Quality Improvement Plan: Update Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, to include the monitoring conducted to ensure providers adhere to these guidelines.	✓		
Utilization Management				
During onsite discussion, Healthy Blue described that Milliman Clinical Guidelines (MCG), and internal evidenced based clinical criteria are utilized in performing clinical determinations. However, the specific clinical criteria guidelines are not outlined in policy or Program Descriptions.	Recommendation: 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 described 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.	Quality Improvement Plan: Update 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: • The Provider Manual and Member Handbook provided different addresses and telephone numbers for members to file an appeal. • There was a conflict in the timeframe for Healthy Blue acknowledging an appeal. The Provider lists the timeframe	Quality Improvement Plan: Correct the errors identified in Healthy Blue's Provider Manual, Member Handbook, the Utilization Review Manual, and in policy MCD-AP-10, Member Appeals Process, related to the procedures and processes for filing an appeal.			✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
as five calendar days, Policy MCD-AP-10, Member Appeals Process, and the Member Handbook list this timeframe as 10 days. • Policy MCD-AP-10, Member Appeals Process, states that the Acknowledgement Letter advises the member/authorized representative of their right to present evidence in person or in writing within seven days of receipt of the Acknowledgement letter. However, the Acknowledgement Letter does not include the member's right to present evidence in person. Also, the Member Handbook (page 61) lists the timeframe for presenting evidence or additional information as 10 days. • The Utilization Review Manual states "only the member has preservice appeal rights can initiate an appeal in writing with the member's signature" and does not align with the contract requirements or Healthy Blue's policy that a member may submit an appeal verbally or in writing within 60 calendar days after an adverse benefit decision. • The Utilization Review Manual incorrectly listed the timeframe for filing an appeal as 180 days.				
The issues regarding the timeliness for notification and resolution of an appeal are as follows: • Policy MCD-AP-10, Member Appeals Process, the Extension Notification letter template, the Provider Manual, and the Member Handbook include the requirements for requesting an extension for Standard Appeals. However, the Member Handbook, the Extension Notification letter template, and Policy MCD-AP-10, Member Appeals Process do not include the extension requirements for an Expedited Appeal request. • The Provider Manual does not include the contractual requirement to give the member prompt oral notification if Healthy Blue requests an extension. • CarelonRx Policy RX-URA-04 , Appeals Process_Medicaid, does not provide	Quality Improvement Plan: The deficiencies regarding the timeliness for notification and resolution of an appeal should be corrected.		✓	

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
the contractual requirement of notifying the member if an expedited request for an appeal resolution is denied. • Healthy Blue's Customer Service Training Curriculum (page 330) does not mention the contractual requirement to give the member prompt oral notification if an expedited request for an appeal resolution is denied. • The CarelonRx Policy RX-URA-07, External Appeal_Medicaid, is not specific regarding the timeframe for filing a State Fair Hearing. The policy notes the timeframe as "no less than 90 days and no more than 120 calendar days from the date of the appeal resolution." The *SCDHHS Contract, Section 9.1.6.3.1.1* notes this timeframe as no later than 120 calendar days.				
Healthy Blue's Member Handbook, Provider Manual, and various letter templates describe the requirements for continuation of benefits for members while in the appeals process. However, Policy MCD-AP-10, Member Appeals Process does not provide the guidelines of continuation of benefits process for members while in the appeal process.	Quality Improvement Plan: Update the appeal policy to include the continuation of benefits process for members while in the appeals process as required by *SCDHHS Contract*.			✓

METHODOLOGY

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

On July 18, 2023, Constellation Quality Health sent notification to Healthy Blue that the Readiness Review was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow the health plan to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Healthy Blue and reviewed in Constellation Quality Health's offices (*see Attachment 1*). These items focused on administrative functions, member educational materials, and the Quality Improvement and Medical Management Programs.

The second segment was a virtual onsite review conducted on October 10, 2023. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Heathy Blue's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

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

A. Administration

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

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

Healthy Blue's processes for developing, managing, and conducting annual review and revisions of policies and procedures are described in Policy MCD-CP 15, Policy Development, Review, and Management. Onsite discussion confirmed all policies will be reviewed and approved by the Policy Committee and reported to the Compliance Committee. However, Policy MCD-CP 15 mentions only that the Compliance Committee is responsible for reviewing and approving policies at least annually. It does not mention the Policy Committee's role in policy review and approval. A defined format has been developed for policies and procedures. Each policy will include a policy header that lists the policy's policy number, subject, department, effective date, revision dates, and product line. Also, each policy will include approval signatures and a history of revisions. Departmental leadership and a bi-monthly compliance newsletter will inform staff about any new or newly revised policies. Staff will be able to access policies through a shared drive and policies will also be accessible on DoubleCheck, a policy management platform.

Review of the Organizational Chart and corresponding onsite discussion confirmed that all key positions are filled, and staffing projections appear to be adequate. Although several vacancies were noted on the Organizational Chart, Healthy Blue reported that all vacant positions have either been filled or recruitment activities are in progress. All staff will be located in South Carolina.

Healthy Blue submitted a written Compliance Plan. It was noted that the Compliance Plan has not yet been approved. Onsite discussion confirmed that it will be presented to the Compliance Committee in November 2023 for approval. Attachments to the Compliance Plan include the Compliance and Program Integrity Organizational Chart, the Compliance Committee Membership List, the Delegated Vendor Management and Oversight Policy, and the Healthy Blue Antifraud Plan. In addition, related policies were submitted that addressed topics including, but not limited to privacy, confidentiality, fraud, waste, and abuse (FWA); and the False Claims Act. The Antifraud Plan describes processes for identifying, detecting, and preventing FWA in the Medicaid program. It also describes investigative processes for FWA conducted by the Special Investigations Unit (SIU), which operates within the Corporate Audit, Compliance and Privacy division and provides services for Healthy Blue.

The Compliance Officer reports to the Chief Executive Officer, chairs the Compliance Committee, and oversees all compliance activities. In addition, the Compliance Officer develops and implements policies, procedures, and activities to ensure compliance with all federal, state, and contractual requirements. The Program Integrity Coordinator works with the Special Investigations Unit (SIU) to coordinate FWA activities with the SCDHHS Division of Program Integrity.

The Compliance Committee reports to the Managed Care Oversight Committee (MCOC) and oversees the Healthy Blue Policy Committee. The Compliance Committee reports through the MCOC to the Board of Directors. As noted above, the Healthy Blue Compliance Committee will commence operations in November 2023. The committee will meet at least monthly with additional meetings held as needed. The committee quorum is defined as the presence of 50% of the voting members.

The Compliance Plan addresses Healthy Blue's expectation for ethical business conduct. Healthy Blue's Code of Conduct, titled "2023 Compliance Overview and Our Values," expands on the information in the Compliance Plan and includes comprehensive information so staff will understand the expectations for appropriate business conduct. The document is comprehensive and covers many topics, including laws and regulations related to FWA, reporting responsibilities for compliance and FWA concerns, avenues for reporting, contact information for reporting these concerns, etc. The document references related policies and procedures and includes a glossary of terminology.

New employment orientation is mandatory on the first day of employment and includes the Code of Conduct, FWA, conflicts of interest, and employee disciplinary and counseling processes. In addition, employees are required to complete the Corporate Compliance and FWA training within 90 days of hire and annually. Training is also provided when there is a reassignment of job functions, for changes in guidelines, if employees violate regulations, etc. In addition to formal training activities, 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.

Healthy Blue encourages open communication by allowing anonymous reporting and prohibiting retaliation or intimidation of any employee who makes good faith reports of compliance issues or suspected FWA. Healthy Blue also maintains an open-door policy to encourage communication and reporting.

Healthy Blue's Pharmacy Lock-in Program processes and requirements are found in Policy RX LOCK SC 43150, Lock-In SC Medicaid – Healthy Blue SC. The policy includes all contractually required elements for the Pharmacy Lock-In Program. However, it does not state the specific timeframe for notifying members of their inclusion in the program. The Lock-in Program is overseen by the pharmacy benefit manager.

Policy MCD-CP 12, Privacy and Confidentiality, provides detailed and comprehensive information about processes Healthy Blue has implemented to ensure member privacy and the confidentiality of protected health information.

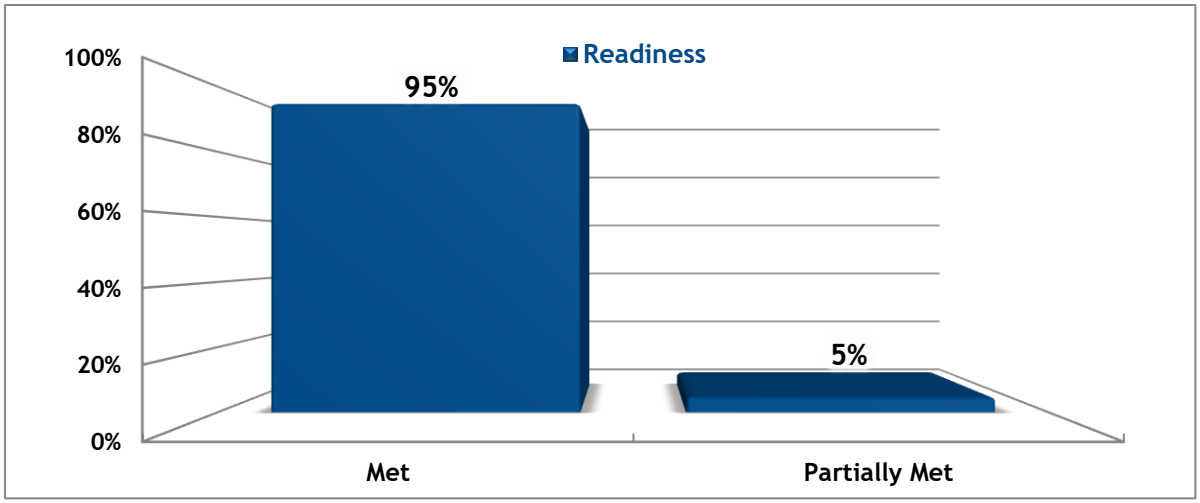
Information Management Systems

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

Healthy Blue's documentation indicates the MCO's information systems, policies, and procedures are able to meet the State's contract requirements. The organization adheres to best practices in monitoring and responding to potential security issues. Additionally, Healthy Blue performs regular audits to validate the performance of its system controls. The audit results provided show Healthy Blue has the necessary measures to protect data and control access. No outstanding issues were found in the audits and the audit results helped identify possible improvements or efficiencies that could be implemented. Finally, Healthy Blue has been efficient in regularly reviewing documentation and keeping it up to date.

Healthy Blue met 95% of the standards in the Administration section for the Readiness Review. *Figure 2: Administration Findings* provides an overview of the scores in the Administration section.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number

Table 5: Administration Standards Needing Improvements

Section	Standard	Readiness Review
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

Section	Standard	Readiness Review
Compliance/Program Integrity	The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Partially Met

The standards reflected in the table are only the standards that received a score less than a Met.

Table 6: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place for developing, managing, reviewing, and revising policies and procedures.	✓		
Key positions are filled, and projected staffing appears to be adequate and meets contractual requirements.	✓		
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 fraud, waste, and abuse.	✓		
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.	✓		

Table 7: Administration Weaknesses, Quality Improvement Plans or Recommendations

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Onsite discussion confirmed policies will be reviewed by the Policy Committee and reported to the Compliance Committee. However, Policy MCD-CP 15 does not	Quality Improvement Plan: Revise Policy MCD-CP 15 to include the Policy Committee's role in policy review and approval.		✓	

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
mention the Policy Committee's role in 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.	Quality Improvement Plan: Revise Policy RX LOCK SC 43150, Lock-In SC Medicaid – Healthy Blue SC, to include the specific timeframe for notifying members of their inclusion in the lock-in program. As noted in the *SCDHHS Contract, Section 11.10.2.1*, the timeframe for member notification is no later than 30 calendar days prior to the effective lock-in date.			✓

I. ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.		X				Policy MCD-CP 15, Policy Development, Review, and Management, describes processes that will be followed for developing, managing, reviewing, and revising policies and procedures. As noted, each business unit or functional area will be responsible for developing policies and conducting annual and ad hoc policy reviews and revisions. Onsite discussion confirmed policies will be reviewed by the Policy Committee and reported to the Compliance Committee. However, Policy MCD-CP 15 states only, "The Healthy Blue Compliance Committee is responsible for reviewing and approving all policies at least annually." It does not mention the Policy Committee's role in policy review and approval. Departmental leadership will be responsible for educating staff about new and revised policies. In addition, a bi-monthly compliance newsletter will inform staff about any new or newly revised policies. Staff will be able to access policies through a shared drive and policies will

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						also be housed on DoubleCheck, a policy management platform. *Quality Improvement Plan: Revise Policy MCD-CP 15 to include the Policy Committee's role in policy review and approval.*
2. Policies and procedures are organized in a consistent, understandable format identifiable to applicable line(s) of business under review.	X					As confirmed during onsite discussion, policies will be grouped by department or functional area and a standard format will be used for policies, which will include a policy header that lists: • Subject • Policy Number • Department • Effective Date • Revision Date • Product Line Also, each policy will include approval signatures and a history of revisions.
3. Policies and procedures will be updated on a routine basis at a minimum of every two years.	X					
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Tim Vaughn is President and Chief Operating Officer.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Chief Financial Officer (CFO);	X					Jennifer Thorne is Chief Financial Officer.
1.3 * Contract Manager;	X					Christian Soura, Vice President of Medicaid Managed Care, will serve as the Contract Manager.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Kevin Dinkins is the Manager of Claims and Charmelle Johnson is the Claims Supervisor. James Thompson is the Senior Manager, Business Analyst, and will oversee encounter data management.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Jennifer Gantt is the Director of Care Management.
1.5.1 Pharmacy Director,	X					Jay Patel is Healthy Blue's Chief Pharmacy Officer and serves as the Pharmacy Director for Healthy Blue.
1.5.2 Utilization Review Staff,	X					All utilization management staff will be located in South Carolina. Several vacancies are noted on the Organizational Chart, but Healthy Blue reported that all vacant positions are in recruitment.
1.5.3 *Case Management Staff,	X					All Case Management staff will be located in South Carolina. Healthy Blue reported that offers have been extended for all positions reported as vacant on

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Organizational Chart for Case Management.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Wanda Allison is the acting Director of Quality. During the onsite, she reported that she plans to retire at the end of 2023 and that recruitment activities are ongoing to secure a replacement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Staffing appears to be adequate. Although several vacancies were noted on the Organizational Chart, Healthy Blue reported during the onsite that all vacant positions have either been filled or recruitment activities are in progress.
1.7 *Provider Services Manager;	X					Tammy Betts is the Director of Provider Services.
1.7.1 *Provider Services Staff,	X					Provider Services staff include one Manager, Provider Education & Outreach, nine Provider Relations Consultants (two vacancies noted), one Data Analyst III, one QC/Training Lead (vacant). Onsite discussion confirmed recruitment activities are in progress to fill the vacancies.
1.8 *Member Services Manager;	X					Latisha Belton is the Manager of Member Services.
1.8.1 Member Services Staff,	X					Projected staffing reflects adequate staffing in the Member Services area. Currently, all positions are vacant except for two Customer Service Coordinators. Recruitment activities are ongoing.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 *Medical Director;	X					Lloyd Kapp, MD is the Medical Director.
1.10 *Compliance Officer;	X					Billy Quarles is the Director of Compliance and serves as the Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					Gina Blyther as the Program Integrity Coordinator.
1.10.2 Compliance /Program Integrity Staff;	X					Compliance/Program Integrity staffing appears to be sufficient to conduct required activities. Four vacancies are noted for RN Review and Data Analyst staff. Healthy Blue reported that interviews for these positions will be conducted within the next week.
1.10.3 *Program Integrity FWA Investigative/Review Staff;	X					Healthy Blue reported that two investigators will be on staff with the addition of a third when membership approaches 200,000 members. All will be located in SC.
1.11 * Interagency Liaison;	X					Laura Brandon as the Interagency Liaison.
1.12 Legal Staff;	X					Melanie Joseph, JD is Healthy Blue's Legal Counsel.
1.13 *Behavioral Health Director	X					Jennifer Pender, MD is the Behavioral Health Director. She is board-certified in psychiatry and in child and adolescent psychiatry
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO processes provider claims in an accurate and timely fashion.	X					Because this is a Readiness Review, Healthy Blue did not present any historical timeliness statistics for this contract. However, it was noted that the MCO expects 98% of claims to be processed in 30 days, and 99% of claims in 90 days.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Healthy Blue is capable of accepting electronic claims and paper claims. Specifically, the MCO uses standardized claims forms such as UB92 and HCFA.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation states the MCO tracks enrollment and demographic data. Additionally, Healthy Blue is able to link previous encounter data across multiple product lines. Healthy Blue's systems rely on unique Medicaid member numbers to identify each member and as a result systems are setup to not permit duplicate entries for each unique Medicaid member number.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Healthy Blue has systems in place to provide the State with HEDIS reports on the data it collects. The MCO's HEDIS systems monitor and document performance data monthly. Finally, the MCO's HEDIS processes are audited yearly to validate its data.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Healthy Blue has aligned its security policies and procedures with the HIPAA security rule. As a result, it uses multi-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						factor authentication routines to gain physical access to the facilities which house data. Additionally, all access is logged and monitored to ensure only those authorized can gain access. The MCO's documentation states that all failed access attempts generate alerts and are investigated by security personnel.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Healthy Blue uses the principle of least privilege to limit system access. Additionally, there are systems in place to monitor network activity and notify security analysts when potential threats are encountered. Finally, ISCA documentation states that security awareness training is given to employees and contractors during the new hire process and on a yearly basis.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Healthy Blue has an extensive and well documented disaster recovery (DR) / business continuity plan (BCP). The plan incorporates geographically dispersed systems to maintain availability in the event of a disaster. The DR plan is tested annually, and the most recent test was a successful tabletop exercise focused on addressing ransomware threats.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Onsite discussion confirmed that the Compliance Plan submitted for review will be presented to the Compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee for approval in November 2023. The Compliance Plan includes the following attachments: • Attachment A – Compliance and Program Integrity Organizational Chart • Attachment B – Compliance Committee Membership List • Attachment C - Delegated Vendor Management and Oversight Policy • Attachment D - Healthy Blue Antifraud Plan In addition to the Compliance Plan, Healthy Blue submitted the following policies: • Policy CP 10, Impermissible Disclosure of Member Information - HIPAA Privacy Reporting • Policy CP 11, Delegated Vendor Management and Oversight • Policy CP 12, Privacy and Confidentiality • Policy CP 13, False Claims Act • Policy CP 14, Fraud Waste and Abuse • Policy CP 16, SC Insurance Data Security Act • Policy CP 17, Compliance Committee Charter • Policy CP 19, Regulatory Alert Process
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.1 Standards of conduct;						The Compliance Plan addresses Healthy Blue's expectation for ethical business conduct and states the "Our Values" document expands on the information in the Compliance Plan and serves as the Code of Conduct. The "Our Values" document is given to all new employees within 90-days and to delegated entities at the time of contracting. Staff may also access the document via the corporate intranet. Staff are required to complete "Our Values" training at employment and annually. "Our Values" is reviewed at least annually and updated as needed for changes in laws, regulations, etc. Healthy Blue's Code of Conduct, titled "2023 Compliance Overview and Our Values," is thorough and includes comprehensive information so staff will understand the expectations for appropriate business conduct. The document covers: • The Compliance Program and the Healthy Blue's values. • Reporting responsibilities, avenues for reporting, and related telephone numbers, email addresses, etc. • Privacy and security requirements. • Laws and regulations related to fraud, waste, and abuse (FWA).

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The document references related policies and procedures for staff to get more information and includes a glossary of terminology.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan addresses the roles of the Compliance Officer and Program Integrity Coordinator. The Compliance Officer reports to the Chief Executive Officer, chairs the Compliance Committee, and oversees all compliance activities. In addition, the Compliance Officer develops and implements policies, procedures, and activities to ensure compliance with all federal, state, and contractual requirements. The Program Integrity Coordinator works with the Special Investigations Unit (SIU) to coordinate FWA activities with the SCDHHS Division of Program Integrity.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						As noted in the Compliance Plan, new employee orientation is mandatory on the first day of employment. The orientation includes the code of conduct, FWA, conflicts of interest, and employee disciplinary and counseling processes. Within 90 days of hire,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						employees are required to complete the Corporate Compliance (Our Values) and FWA training. The "Our Values" training includes a privacy and security overview. FWA training is also provided when there is a reassignment of job functions, for changes in guidelines, if employees violate regulations, etc. All employees must complete annual training on compliance, FWA, and a review of the initial "Our Values" course. Departments that routinely interact with protected health information are required to complete additional data privacy and protection training courses. In addition to the formal training, 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.
2.6 Lines of communication;						The Compliance Plan addresses lines of communication that are maintained between the Compliance Officer and staff. To promote open and effective communication, Healthy Blue prohibits retaliation or intimidation of any employee who makes good faith reports of compliance issues or suspected FWA. Healthy Blue also maintains an open-

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						door policy to encourage communication and reporting. Healthy Blue posts and publishes contact information for the Compliance Officer and other compliance staff. The Compliance Hotline allows anonymous reporting of possible compliance violations and related issues. Healthy Blue also educates members and providers about methods of reporting of potential FWA through explanations of benefits, the plan website, member and provider newsletters and mailings, the Member Handbook, and the Provider Manual.
2.7 Enforcement and accessibility;						When non-compliant or unethical behavior is confirmed, Healthy Blue responds with timely, consistent, and appropriate enforcement action against all persons involved. Specific disciplinary actions are not mandated for specific violations—each incident is addressed on a case-by-case basis. However, the "Our Values" document as well as compliance training, policies, etc. cover possible disciplinary action that may result from non-compliance or FWA activities.
2.8 Internal monitoring and auditing;						The Compliance Plan provides information about routine internal monitoring and auditing activities. The activities include:

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Developing a master audit plan that considers risk and other factors. This will be approved yearly by the Compliance Committee. • Communicating the audit to area management. • Conducting a pre-audit meeting with area management to discuss audit objectives and parameters. • Conducting the audit and documenting information to support conclusions and recommendations. • Reporting draft and final results to Senior Management and the Compliance Committee. • Following up on audit findings and recommendations within six months of expected implementation of any corrective action plan. Auditing and monitoring will also be conducted of delegated entities as addressed in the Delegated Vendor Management and Oversight Policy.
2.9 Response to offenses and corrective action;						When incidents of non-compliance are discovered, Healthy Blue will self-report the incident to CMS and/or SCDHHS as soon as possible to get guidance on actions to take to limit impact on members and to avoid potential sanctions or exclusions from

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						participation in state and federal health care programs. Healthy Blue will have procedures for voluntarily self-reporting incidents of FWA or misconduct SCDHHS or other applicable governmental entities, such as the OIG, Department of Justice, or the South Carolina Medicaid Fraud Control Unit (MFCU). The Special Investigations Unit (SIU) will investigate compliance or FWA issues and coordinate referrals to internal departments such as Compliance and Human Resources, and to regulatory bodies when appropriate. The Compliance Department will ensure appropriate corrective action is taken when noncompliance or FWA has been detected. If related to federal and/or state standards for critical functions are consistently not met, Compliance and/or the Business Owner will request a formal corrective action plan to be implemented within 1 month and routine monitoring will be conducted to assess the effectiveness of the CAP. Substantiated violations of company policy or that have the potential for disciplinary action are referred to Human Resources for follow-up with management. If the investigation is related to violation of state or federal law, Compliance will work with the Legal

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Department and Human Resources for guidance about referrals to law enforcement. Healthy Blue keeps records of compliance violations, investigations, and disciplinary actions for 10 years as evidence of timely, consistent, and effective enforcement.
2.10 Data mining, analysis, and reporting;						Data mining is addressed in the Antifraud Plan.
2.11 Exclusion status monitoring.						Processes for ensuring that Healthy Blue does not knowingly hire, contract with, or retain any person or entity that is ineligible to participate in federal or state health care programs are found in the Compliance Plan. All potential employees, providers, and contractors are subjected to a background check, which also includes reviewing federal and state exclusion databases. In addition, all providers and staff are checked monthly against the databases, which are specified in the Compliance Plan.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					Policy MCD-CP 17, Healthy Blue Compliance Committee, states the Compliance Committee's purpose is "to provide a centralized mechanism for addressing compliance initiatives and risk management concerns for the Healthy Blue Medicaid managed care health plan." This committee oversees the Compliance Plan's development and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						implementation, and monitors, reviews, and assesses the effectiveness of the Compliance Plan. As noted in the policy, the Compliance Committee reports to the Managed Care Oversight Committee (MCOC) and oversees the Healthy Blue Policy Committee. Overall responsibilities of the Compliance Committee are detailed in the policy. Attachment B, Committee Organizational Chart, of the 2024 Quality Management and Improvement Program (program description document) indicates the Compliance Committee reports through the MCOC to the Board of Directors. The Compliance Committee will meet at least monthly with additional meetings held as needed. The committee quorum is defined as the presence of 50% of the voting members, who are listed in the policy. Minutes were reviewed for Compliance Committee meetings from 1/23/23 through 7/10/23. The minutes displayed the presence of a quorum for each meeting. Onsite discussion confirmed that these minutes are for the combined Healthy Blue and Amerigroup Compliance Committee, but that beginning in November 2023, a new Compliance Committee for Healthy Blue begin meeting.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Healthy Blue's Medicaid Antifraud Plan describes the MCO's processes for identifying, detecting, and preventing FWA in the Medicaid program. It also describes investigative processes for FWA conducted by the Special Investigations Unit (SIU), which operates within the Corporate Audit, Compliance and Privacy division and provides services for Healthy Blue. As noted in the Antifraud Plan, Healthy Blue uses claims editing software to prevent overpayments. The edits include pre-payment edits at gateway and during adjudication. In addition, post-payment edits are used that can predict and identify FWA schemes by running "algorithms to identify aberrant trends, outlier providers and other flags…" Also, the Fraud, Waste, and Abuse Plan states, "The Payment Integrity area has developed a comprehensive reporting suite to identify Fraud, Waste and Abuse." Examples of the reports are included.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Antifraud Plan lists methods for receiving referrals of potential or suspected FWA and processes followed by the SIU in conducting investigations of potential or suspected FWA.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Processes are in place for recoupment of payments made for items or services furnished, ordered, or prescribed by an excluded individual or entity. Information about recoupments is included in the Antifraud Plan. All recoveries are reported to SCDHHS.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).		X				Healthy Blue's Pharmacy Lock-in Program processes and requirements are documented in Policy RX LOCK SC 43150, Lock-In SC Medicaid – Healthy Blue SC. This program is "designed to identify Healthy Blue South Carolina (Healthy Blue) members who may be over-utilizing prescribers, medications, and pharmacies" and "reduces inappropriate utilization, reduces costs, and improves quality of life through enhanced coordination of care." The Lock-in Program is overseen by the pharmacy benefit manager. The policy includes all contractually required elements for the Pharmacy Lock-In Program, except that it does not provide the specific timeframe for notifying members of their inclusion in the program. The policy states, "Healthy Blue SC is expected to follow the timeline established by the SCDHHS Policy and Procedure Guide for member notification…"

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Revise Policy RX LOCK SC 43150, Lock-In SC Medicaid – Healthy Blue SC, to include the specific timeframe for notifying members of their inclusion in the lock-in program. As noted in the SCDHHS Contract, Section 11.10.2.1, the timeframe for member notification is no later than 30 calendar days prior to the effective lock-in date.
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MCD-CP 12, Privacy and Confidentiality, provides detailed and comprehensive information about processes Healthy Blue has implemented to ensure member privacy and the confidentiality of protected health information.

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.

Policy MCD-CST 16, Plan Educational Materials, describes processes for providing new members within 14 calendar days after Healthy Blue receives the members' enrollment data from SCDHHS. Routine and emergent services are defined in the Member Handbook with instructions for accessing care and resources at the appropriate levels. Benefits are described in the Member Handbook along with applicable co-pays, deductibles, and prior authorization requirements.

Printed materials are made available to members in style and reading levels and in alternate languages as needed. The Member Handbook and Provider Manual provides information on advance directives and for reporting suspected fraud, waste, and abuse (FWA). Policy MCD-CST 16, Plan Educational Materials, indicates that instructions for locating or requesting printed copies of Plan educational materials are included in the initial materials, will be on the Healthy Blue website, in the Member Handbook, and outlined in the Annual Notification to Members letter.

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 SPH analytics (which is now Press Ganey), an accredited vendor for the survey administration, 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.

Steps for primary care provider (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 described in the Member Handbook, the Provider Manual, and will be available on the website.

Grievances

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

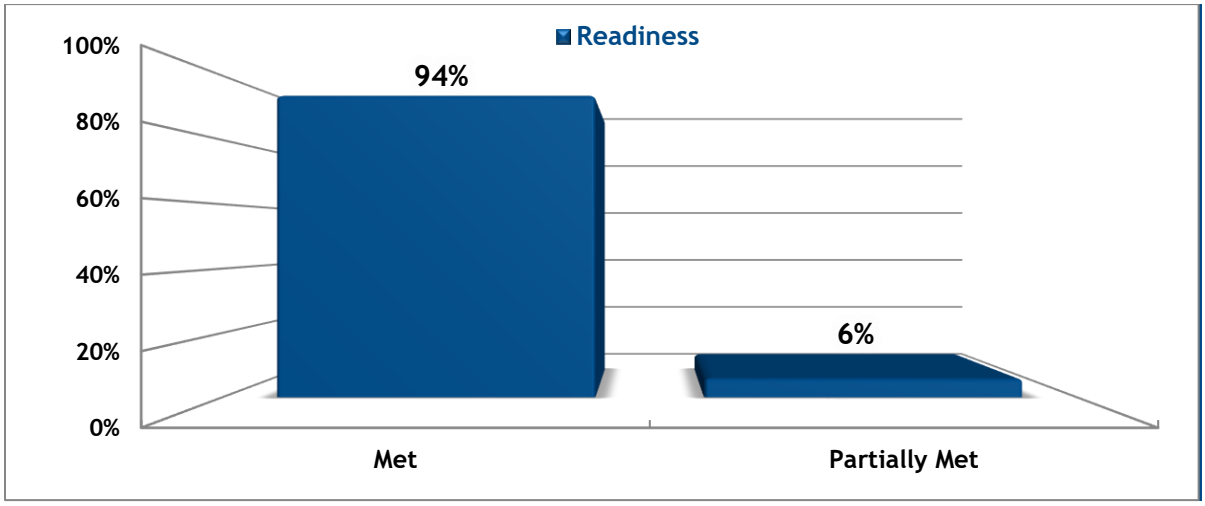
Processes for receiving and processing member grievances are described in Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual. Grievances are defined as the expression, complaint, or dissatisfaction about anything other than Adverse Benefit Determinations. The *SCDHHS Contract, Section 9.1.1.2.1.* allows a member to file a grievance at any time verbally or in writing. Healthy Blue's Member Handbook did not inform the member that a grievance may be filed at any time.

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 (page 94) 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 Provider Manual do 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 resolutions, as required by the *SCDHHS Contract, Section 9.1.6.1.5.2*. 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*).

As noted in *Figure 3: Member Services Findings*, 94% of the standards for Member Services are scored as "Met" and 6% are scored as "Partially Met."

Figure 3: Member Services Findings



Scores were rounded to the nearest whole number

Table 8: Member Services Standards Needing Improvements

Section	Standard	Readiness Review
Grievances	Procedures for filing and handling a grievance;	Partially Met
	Timeliness guidelines for resolution of a grievance;	Partially Met

The standards reflected in the table are only the standards that received a score less than a Met.

Table 9: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
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.			✓

Table 10: Member Services Weaknesses and Recommendations

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy MCD-QM-15, Consumer Assessment of Healthcare Providers and Systems (CAHPS), notes that "actions will	*Recommendation: Include the responsible committee(s) that will initiate the interventions and monitor*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
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.	*their progress for issues identified in the member satisfaction survey.*			
Policy MCD-CST 17, Member Grievances Process, and the Provider Manual indicate that grievances may be filed at any time verbally or in writing. However, the Member Handbook did not include the wording about the ability to file a grievance at any time.	*Recommendation: 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.*	✓		
Policy MCD-CST 17, Member Grievances Process, states, "All Grievances have an acknowledgment letter sent within 7 days of receipt." The Provider Manual (page 94) 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."	*Quality Improvement Plan: Correct the timeframe for acknowledging a grievance in the Provider Manual.*		✓	
Timelines for grievance resolution were accurately outlined in Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual. 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 also 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 Provider Manual do 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 resolutions. as required by the *SCDHHS Contract, Section 9.1.6.1.5.2.* 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*).	*Quality Improvement Plan: Correct policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual and 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 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.*		✓	

II. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. MEMBER SERVICES						
II A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Member rights and responsibilities are outlined consistently and comprehensively in Policy MCD-CST 18, Member Rights and Responsibilities, the Member Handbook, and Provider Manual.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
II B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Healthy Blue will provide new members educational materials within 14 calendar days of receiving the members' enrollment data per Policy MCD-CST 16, Plan Educational Materials.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						The Member Handbook details the right to a second opinion from an out-of-network provider and requires prior authorization.
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Definitions and examples of routine and emergent services are outlined in the Member Handbook with instructions for accessing care and resources at the appropriate levels.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						The Provider Manual and Member Handbook indicate that any changes to benefits are made known to members in writing thirty days prior to the effective date of the change(s).
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook and Provider Manual provide information on programs, services, and resources for Early and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Periodic Screening, Diagnosis and Treatment (EPSDT) services.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						Steps to report suspected fraud, waste, and abuse are outlined in the Member Handbook, Provider Manual, and will be posted on the Healthy Blue website. Examples are included to educate members and providers in recognizing FWA violations.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Policy MCD-CST 16, Plan Educational Materials, describes that instructions for locating or requesting printed copies of plan educational materials will be included in the initial materials, on the Healthy Blue website, in the Member Handbook, and in the Annual Notification to Members letter.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy MCD-CST 16, Plan Educational Materials, describes that materials will accommodate the reading skills of Medicaid members, and will not exceed a 6th-grade reading level.
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
II C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					
II D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
II E. Member Satisfaction Survey						
1. 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:	X					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.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					Policy MCD-QM-15, Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey, notes that the plan will use SPH analytics (which is now Press Ganey), an accredited vendor for the survey administration. The policy notes that "actions will be implemented to address the opportunities for improvement." However, it does not specify which department or committee will be responsible for the development or tracking of any action steps. *Recommendation: Include the committee(s) that will initiate the interventions and*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitor their progress for issues identified in the member satisfaction survey.
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					
II F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a	X					Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual describe processes for filing grievances.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
manner consistent with contract requirements, including, but not limited to:						
1.1 The definition of a grievance and who may file a grievance;	X					Grievances are defined as the expression, complaint, or dissatisfaction about anything other than Adverse Benefit Determinations.
1.2 Procedures for filing and handling a grievance;		X				Policy MCD-CST 17, Member Grievances Process, and the Provider Manual indicate that grievances may be filed at any time verbally or in writing. However, the Member Handbook did not include the wording about the ability to file a grievance at any time. *Recommendation: 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.* Policy MCD-CST 17, Member Grievances Process, states "All Grievances have an acknowledgment letter sent within 7 days of receipt." The Provider Manual (page 94) 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." *Quality Improvement Plan: Correct the timeframe for acknowledging a grievance in the Provider Manual.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;		X				Timelines for grievance resolution were accurately outlined in Policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual. 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 also 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 Provider Manual do 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 resolutions. as required by the *SCDHHS Contract, Section 9.1.6.1.5.2.* 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*). *Quality Improvement Plan: Correct policy MCD-CST 17, Member Grievances Process, the Member Handbook, and Provider Manual and include the requirement to inform the member of the right to file a*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
3. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

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 eleven 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, pages 10 through 13 discuss the program's methodology; however, the "Quality Improvement Model" noted on 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 noted on 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 is 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 and 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. The Quality Navigator's role is to educate 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 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. The evaluation 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 how HEDIS measures will be collected and reported. 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; and Policy MCD-DM 23, Healthcare Effectiveness Data and Information Set (HEDIS) Chase Logic Documentation, offers the chase logic documentation policy which 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)

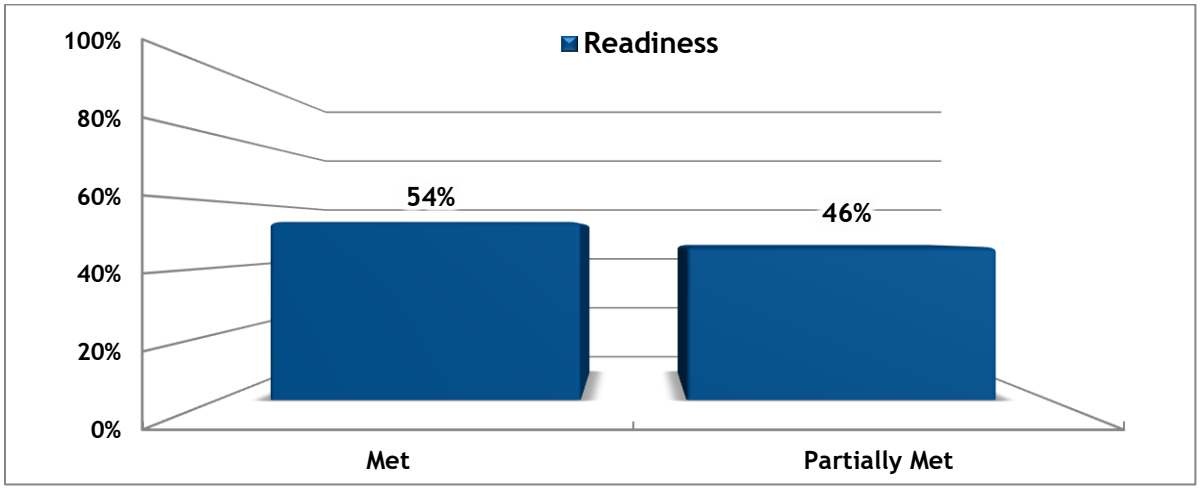
Policy MCD-QM 17, Performance Improvement Projects- Study Selection, Design, Implementation and Evaluation Process, noted the topics for the performance improvement projects will be selected based on plan level data that identifies areas for improvement such as HEDIS and CAHPS data. The policy does not indicate that other performance data, based on priority topics or utilization data, or other system data may

be included as part of the 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 be used for documenting the performance improvement projects. 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, as well as 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, as well as a place for statistical significance testing, when sampling is applied.

For the Readiness Review, 54% of the standards in the Quality Improvement section were scored as "Met." 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.

Figure 4: Quality Improvement Findings



Scores were rounded to the nearest whole number

Table 11: Quality Improvement Standards Needing Improvements

Section	Standard	Readiness Review
The Quality Improvement (QI) Program	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
	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
Performance Measures	The process for collecting and reporting the performance measures are consistent with the requirements of the contract	Partially Met
Quality Improvement Projects	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	Providers will receive interpretation of their QI performance data and feedback regarding QI activities	Partially Met

The standards reflected in the table are only the standards that received a less than Met score.

Table 12: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
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.	✓		

Table 13: Quality Improvement Weaknesses and Recommendations

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The QI program description lacked details regarding staff resources, the methodology to be used in implementing the program, and missing information in the Data Sources section on page 12.	*Quality Improvement Plan: Update the QI Program Description to include other managers and staff supporting the QI program. Include the methodology to be used to implement the program and correct the errors on page 12.*	✓		
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.	*Quality Improvement Plan: The policy must be updated to include a comprehensive list of utilization measures of interest that will address the entire plan population and the plan service domains (inpatient, outpatient, pharmacy, emergency services). The determination of thresholds, including which department and wherein they are derived needs to be added to the policy. Finally, 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, as well as 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).	*Quality Improvement Plan: 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.	*Quality Improvement Plan: 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.*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Healthy Blue's PIP template to be used for documenting the performance improvement projects did not include all the elements that are required by the CMS protocol.	*Quality Improvement Plan: Develop a PIP template protocol that aligns with the elements or requirements in the CMS protocol.*	✓		
Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, discusses the review, adoption, and dissemination of the preventive and clinical practice guidelines. However, this policy does not address the monitoring process to ensure providers adhere to these guidelines.	*Quality Improvement Plan: Update Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, to include the monitoring conducted to ensure providers adhere to these guidelines.*	✓		

III. QUALITY IMPROVEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. QUALITY IMPROVEMENT						
III A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. 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.		X				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 eleven 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, pages 10 through 13 discuss the program's methodology, however; the "Quality Improvement Model" noted on 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 noted on page 12.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update the QI Program Description to include other managers and staff supporting the QI program. Include the methodology to be used to implement the program and correct the errors on page 12.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.		X				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. 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 is 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 just states "interventions are identified for implementation" but there is no information on how this occurs, and if there is a timeframe for corrective actions. *Quality Improvement Plan: The policy must be updated to include a comprehensive list of utilization measures of interest that will address the entire plan population and the plan service domains (inpatient, outpatient, pharmacy, emergency services). The*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determination of thresholds, including which department and wherein they are derived needs to be added to the policy. Finally, 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, as well as the timeline for the escalation.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					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 and will update the work plan frequently.
III B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Healthy Blue's Clinical Quality Improvement Committee is the committee responsible for providing oversight and direction of the QI Program.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The Clinical Quality Improvement 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 is needed for a quorum.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The QI Committee meets at regular quarterly intervals.	X					The Clinical Quality Improvement Committee will meet at least quarterly.
4. Minutes will be maintained that document proceedings of the QI Committee.	X					Per QI Program Description, "Minutes record the practitioner and health plan staff attendance and participation. Minutes are produced within one (1) month following the meeting and are maintained in confidential secure files. Minutes are reviewed and approved by the originating committee and are signed and dated by the committee chair within the month following the approval meeting."
III C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. The process for collecting and reporting the performance measures are consistent with the requirements of the contract.		X				For the performance measure validation, Constellation Quality Health reviewed Healthy Blue's plan for how HEDIS measures will be collected and reported. 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; and Policy MCD-DM 23, Healthcare Effectiveness Data and Information Set (HEDIS) Chase Logic Documentation, offers the chase logic documentation policy which refers to the cross walking and mapping. The overall HEDIS calculation-based policies and procedures were not included. The policies

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						should outline a broader overview of the HEDIS procedures that will be used, including documentation. *Quality Improvement Plan: 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.).*
III D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.		X				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. Although a majority of the PIP topics are derived from HEDIS rates, it is important to maintain a broad scope of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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. *Quality Improvement Plan: 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.*
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				Healthy Blue provided a PIP template to be used for documenting the performance improvement projects. 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, as well as 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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or goal rate. As well as a place for statistical significance testing, when sampling is applied. *Quality Improvement Plan: Develop a PIP template protocol that aligns with the elements or requirements in the CMS protocol.*
III E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers will receive interpretation of their QI performance data and feedback regarding QI activities.		X				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. 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 and clinical practice guidelines. However, this policy does not address the monitoring process to ensure providers adhere to the guidelines.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update Policy MCD-QM 19, Preventive Health and Clinical Practice Guidelines, to include the monitoring conducted to ensure providers adhere to these guidelines.
III F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program will be prepared annually and submitted to the QI Committee and to the MCO Board of Directors.	X					At least annually, Healthy Blue will formally conduct an evaluation of the QI Program. The evaluation 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.

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)

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. CarelonRx serves as Healthy Blue's pharmacy benefit manager and is responsible for implementation and management of all pharmaceutical services for Healthy Blue members.

Dr. Kapp, who is the Chief Medical Director, provides overall oversight of the UM Program. Dr. Draffin serves as Associate Medical Director and manages the day-to-day functions of UM. Dr. Pender, who is the Behavioral Health Medical Director, provides oversight of the behavioral health program and Jay Patel serves as Chief Pharmacy Officer of the Pharmacy Program.

UM Reviewers are licensed practitioners within their respective healthcare disciplines, and perform initial clinical determinations utilizing individual member circumstances, and internal and external clinical guidelines. Healthy Blue described that Milliman Clinical Guidelines (MCG) and internal evidence based clinical criteria are utilized in performing clinical determinations. However, the guidelines and standards were not outlined in policy or in the Program Descriptions. Training is provided to UM Reviewers at hire and ongoing to ensure accountability and consistency in standard authorization reviews. Preceptors also serve as Peer Team Leaders to provide technical assistance and feedback to UM Reviewers. In the event of a potential adverse benefit decision, a second level review is conducted by a licensed physician who has 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.

The processes and requirements for covering hysterectomies, sterilizations, and abortions are described in various policies and related forms are available online for members and providers. Also, the process and guidelines in covering emergency and post stabilization services are outlined in various policies and the Member Handbook.

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. If there are specialized needs identified, targeted case management is provided to members to ensure that the member is receiving the most appropriate level of care. Transitional case management is also offered to members to provide assistance to members when transitioning across healthcare settings, during disenrollment, or enrollment.

Annually, trend reports will be analyzed by Healthy Blue to identify any patterns of over-utilization and under-utilization of services to aid in development of quality improvement measures.

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, as noted in *Table 14: Appeal Deficiencies*.

Table 14: Appeal Deficiencies

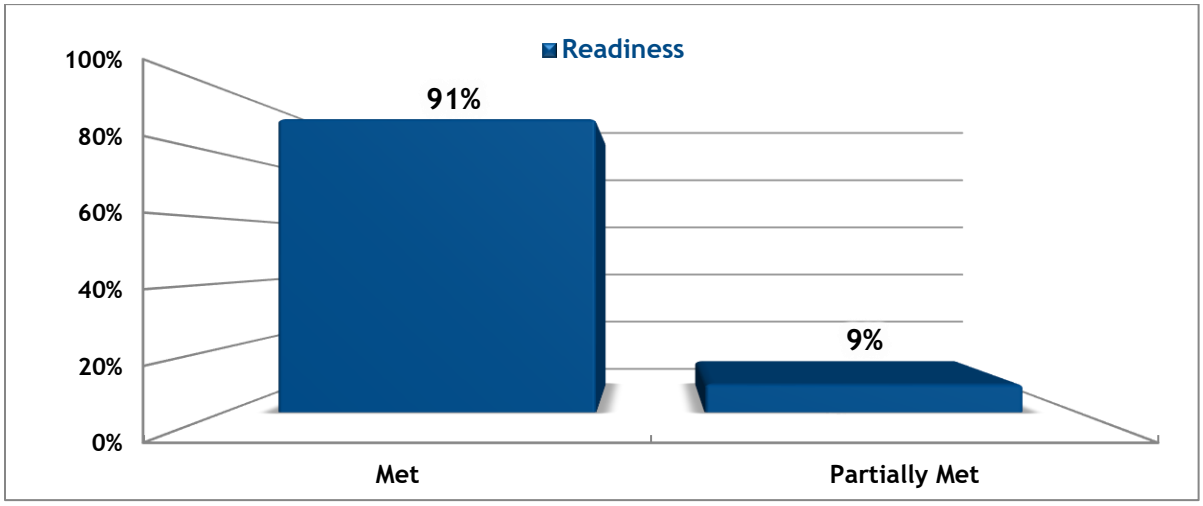
Appeal Requirement	Deficiency
Definition of an Appeal	A member or authorized representative may file an oral or written appeal. The definition of an appeal and adverse benefit decision is described in the Member Handbook and Policy MCD-AP-10, Member Appeals Process. However, the definition of an adverse benefit decision is not included in the Provider Manual.
Procedures and Process for Filing an Appeal	The Provider Manual and Member Handbook provided different addresses and telephone numbers for members to file an appeal.
	There was a conflict in the timeframe for Healthy Blue acknowledging an appeal. The Provider Manual lists the timeframe as five calendar days. Policy MCD-AP-10, Member Appeals Process, and the Member Handbook list this timeframe as 10 days.
	Policy MCD-AP-10, Member Appeals Process, states that the Acknowledgement Letter advises the member/authorized representative of their right to present evidence in person or in writing within seven days of receipt of the Acknowledgement Letter. However, the Acknowledgement Letter does not include the member's right to present evidence in person. Also, the Member Handbook (page 61) lists the timeframe for presenting evidence or additional information as 10 days.
	The Utilization Review Manual states "only the member has preservice appeal rights can initiate an appeal in writing with the member's signature" and does not align with the contract requirements or Healthy Blue's policy that a member may submit an appeal verbally or in writing within 60 calendar days after an adverse benefit decision.

Appeal Requirement	Deficiency
	The Utilization Review Manual incorrectly listed the timeframe for filing an appeal as 180 days.
Timeliness for Notification and Resolution of an Appeal	Policy MCD-AP-10, Member Appeals Process, the Extension Notification letter template, the Provider Manual, and the Member Handbook include the requirements for requesting an extension for standard appeals. However, the Member Handbook, the Extension Notification letter template, and Policy MCD-AP-10, Member Appeals Process, do not include the extension requirements for an Expedited Appeal request.
	The Provider Manual does not include the contractual requirement to give the member prompt oral notification if Healthy Blue requests an extension.
	CarelonRx Policy RX-URA-04, Appeals Process_Medicaid, does not include the contractual requirement of notifying the member if a request for expedited appeal resolution is denied.
	Healthy Blue's Customer Service Training Curriculum (page 330) does not mention the contractual requirement to give the member prompt oral notification if an expedited request for an appeal resolution is denied.
	The CarelonRx Policy RX-URA-07, External Appeal_Medicaid, is not specific regarding the timeframe for filing a State Fair Hearing. The policy notes the timeframe as "no less than 90 days and no more than 120 calendar days from the date of the appeal resolution." The *SCDHHS Contract, Section 9.1.6.3.1.1* notes this timeframe as no later than 120 calendar days.
Continuation of Benefits	Healthy Blue's Member Handbook, Provider Manual, and various letter templates describe the requirements for continuation of benefits for members while in the appeal process. However, Policy MCD-AP-10, Member Appeals Process, does not provide the guidelines of continuation of benefits process for members while in the appeal process.

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.

As noted in *Figure 5:* Utilization Management Findings, Healthy Blue achieved "Met" scores for 91% of the Utilization Management standards.

Figure 5: Utilization Management Findings



Scores were rounded to the nearest whole number

Table 15: Utilization Management Standards Needing Improvement

Section	Standard	Readiness Review
Appeals	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: 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
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met
	Other requirements as specified in the contract	Partially Met

The standards reflected in the table are only the standards that received a less than Met score.

Table 16: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
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.	✓		

Strengths	Quality	Timeliness	Access to Care
Healthy Blue conducts scheduled Staff Review Check-ins to assess any employee needs and provide supervision as needed.	✓		

Table 17: Utilization Management Weaknesses and Recommendations

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
During onsite discussion, 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.	*Recommendation: 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 an adverse benefit decision are described 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.	*Quality Improvement Plan: Update the definition of an adverse benefit decision in the Provider Manual.*	✓		
The procedures for filing an appeal are outlined in Policy MCD-AP-10, Member Appeals Process, Member Handbook, Provider Manual, and the Utilization Review Manual. There were several identified issues with Healthy Blue's procedures for filing an appeal: • The Provider Manual and Member Handbook provided different addresses and telephone numbers for members to file an appeal. • There was a conflict in the timeframe for Healthy Blue acknowledging an appeal. The Provider lists the timeframe as five calendar days. Policy MCD-AP-10, Member Appeals Process, and the Member Handbook list this timeframe as 10 days. • Policy MCD-AP-10, Member Appeals Process, states that the Acknowledgement Letter advises the member/authorized representative of their right to present evidence in person or in writing within seven days of receipt of the Acknowledgement Letter.	*Quality Improvement Plan: Correct the errors identified in Healthy Blue's Provider Manual, Member Handbook, the Utilization Review Manual, and in policy MCD-AP-10, Member Appeals Process, related to the Procedures and Process for Filing an Appeal.*			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
However, the Acknowledgement Letter does not include the member's right to present evidence in person. Also, the Member Handbook (page 61) lists the timeframe for presenting evidence or additional information as 10 days. • The Utilization Review Manual states "only the member has preservice appeal rights can initiate an appeal in writing with the member's signature" and does not align with the contract requirements or Healthy Blue's policy that a member may submit an appeal verbally or in writing within 60 calendar days after an adverse benefit decision. • The Utilization Review Manual incorrectly listed the timeframe for filing an appeal as 180 days.				
The issues regarding the timeliness for notification and resolution of an appeal are as follows: • Policy MCD-AP-10, Member Appeals Process, the Extension Notification letter template, the Provider Manual, and the Member Handbook include the requirements for requesting an extension for standard appeals. However, the Member Handbook, the Extension Notification letter template, and Policy MCD-AP-10, Member Appeals, do not include the extension requirements for an expedited appeal request. • The Provider Manual does not include the contractual requirement to give the member prompt oral notification if Healthy Blue requests an extension. • CarelonRx Policy RX-URA-04, Appeals Process_Medicaid, does not provide the contractual requirement of notifying the member if a request for expedited appeal resolution is denied. • Healthy Blue's Customer Service Training Curriculum (page 330) does not mention the contractual requirement to give the member prompt oral notification if a request for expedited appeal resolution is denied. • The CarelonRx Policy RX-URA-07, External Appeal_Medicaid is not specific regarding the timeframe for filing a State	*Quality Improvement Plan: The deficiencies regarding the timeliness for notification and resolution of an appeal should be corrected.*		✓	

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Fair Hearing. The policy notes the timeframe as "no less than 90 days and no more than 120 calendar days from the date of the appeal resolution." The *SCDHHS Contract, Section 9.1.6.3.1.1,* notes this timeframe as no later than 120 calendar days.				
Healthy Blue's Member Handbook, Provider Manual, and various letter templates describe the requirements for continuation of benefits for members while in the appeals process. However, Policy MCD-AP-10, Member Appeals Process does not provide the guidelines of continuation of benefits process for members while in the appeals process.	*Quality Improvement Plan: Update the appeal policy to include the continuation of benefits process for members while in the appeals process as required by SCDHHS Contract.*			✓

IV. UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. Utilization Management						
IV A. The Utilization Management (UM) Program						
1. The MCO has in place policies and procedures that describe its utilization management program, including but not limited to:	X					Healthy Blue's Medicaid Integrated Care Management Plan and Policy RX URA-02, Utilization Review Process-Medicaid, provides a descriptive overview of the health plan's scope and objectives for physical health and behavioral health services. The Pharmacy Program Description outlines the pharmacy program's process and standard operations.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					Policy RX URA-02, Utilization Review Process _ Medicaid, describes Healthy Blue's utilization review process that consists of reviewing the necessary information that is consistent with the clinical review criteria for behavioral health, pharmacy, and physical health services. The criteria utilized for making clinical determinations is available to providers and members upon request as outlined in Policy MCD-UM 21, Request for Medical Policies Guidelines Criteria or Benefit.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					Healthy Blue's Preferred Provider Program is offered to providers with an 80% or greater approval rate of authorizations and is audited annually to assess continual participation as described in the Medicaid Integrated Care Management Plan.
2. Utilization management activities will occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Dr. Kapp, who is the Chief Medical Director, provides overall oversight of the UM Program. Dr. Draffin serves as Associate Medical Director and manages the day-to-day functions of UM and performs second level reviews. Dr. Pender, who is the Behavioral Health Medical Director, provides oversight of the behavioral health program, and Jay Patel serves as Chief Pharmacy Officer of the Pharmacy Program.
3. 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.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria to be used are in place for determining medical necessity for all covered benefit situations.	X					During onsite discussion, Healthy Blue indicated that Milliman Clinical Guidelines (MCG) and internal evidenced based clinical criteria are used in making clinical determinations. However, the specific clinical criteria guidelines are not outlined in policy or in Program Descriptions. The initial review is conducted by assessing the provided clinical information against established clinical guidelines. If the clinical information does not appear to meet clinical criteria, a second level review is conducted as described in Policy RX URA-02, Utilization Review Process_Medicaid, and Medicaid Integrated Care Management Plan. The pharmacy utilization UM review process entails a review of patients' prescription medication data, approved clinical criteria guidelines, and individual member data to make clinical determinations as described in Policy RX UM 43301, Drug Utilization Review-Healthy Blue SC, Policy RX PA 43351, Pharmacy Prior Authorization-Healthy Blue SC, and Healthy Blue's Pharmacy Program Description. *Recommendation: Include the evidenced based standards and criteria that will be utilized for*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determining medical necessity in a policy or in the UM Program Description.
2. Utilization management decisions will be made using predetermined standards/criteria and all available medical information.	X					
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Processes and requirements for covering hysterectomies, sterilizations, and abortions are described in Policy MCD-UM 12, Sterilizations and Hysterectomies, and Policy MCD UM 32, Abortions. During onsite discussion, Healthy Blue stated that the forms will be available online for the members and providers to download and complete.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria will be consistently applied to all members across all reviewers.	X					
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Healthy Blue's current pharmacy benefit manager is CarelonRx. CarelonRx is responsible for implementation and management of all pharmaceutical services for Healthy Blue members including prior authorization, drug utilization review programs, and management of the Pharmacy Lock-In Program as described in various polices and the Pharmacy Program Description.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care will be provided in a manner consistent with the contract and federal regulations.	X					Healthy Blue's process and guidelines for covering emergency and post stabilization services are outlined in Policy MCD-UM 10, 24 Hour Access to Emergency Services, and the Member Handbook. Emergency services are provided at no cost to members.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions will be made by appropriately trained reviewers.	X					Initial clinical reviews are performed by healthcare professionals that are licensed in their respective fields. During onsite discussion, Healthy Blue described their training and onboarding process. The process entails approximately three weeks of training that encompasses peer shadowing, training modules completion, and practice testing. The health plan also conducts 30, 60, and 90-day interval Staff Review Check-Ins to assess any employee needs and provide supervision as needed. Lastly, UM Reviewers are also assigned Preceptors, which are Peer Team Leaders that are available to provide technical assistance and feedback as needed.
10. Initial utilization decisions will be made promptly after all necessary information is received.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11. Denials						
11.1 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 services.	X					
11.2 All decisions to deny services based on medical necessity will be reviewed by an appropriate physician specialist.	X					
11.3 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.	X					
IV C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. 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:	X					Healthy Blue's appeals process is outlined in the Utilization Management Program Description, Provider Manual, Member Handbook, Policy MCD-AP 10, Member Appeals, Policy RX URA-04, Appeals Process Medicaid, and Policy RX URA-07, External Appeals Medicaid.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				A member or authorized representative may file an oral or written appeal as outlined in the Provider Manual, Member Handbook, the Medicaid Integrated Care Management Plan, and Policy MCD-AP-10, Member Appeals. Also, the definitions of an appeal and an adverse

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						benefit decision are described 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. *Quality Improvement Plan: Update the definition of an adverse benefit decision in the Provider Manual.*
1.2 The procedure for filing an appeal;		X				The procedures for filing an appeal are outlined in Policy MCD-AP-10, Member Appeals, Member Handbook, Provider Manual, and the Utilization Review Manual. There were several identified issues with Healthy Blue's procedures for filing an appeal: • The Provider Manual and Member Handbook provided different addresses and telephone numbers for members to file an appeal. • There was a conflict in the timeframe for Healthy Blue acknowledging an appeal. The Provider Manual lists the timeframe as five calendar days. Policy MCD-AP-10, Member Appeals Process, and the Member Handbook list this timeframe as 10 days. • Policy MCD-AP-10, Member Appeals Process, states that the Acknowledgement Letter advises the member/authorized representative of their right to present evidence in person or in writing within seven days of receipt of the Acknowledgement Letter. However, the Acknowledgement Letter does not include the member's right to present evidence in person. Also, the Member

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Handbook (page 61) lists the timeframe for presenting evidence or additional information as 10 days. • The Utilization Review Manual states "only the member has preservice appeal rights can initiate an appeal in writing with the member's signature" and does not align with the contract requirements or Healthy Blue's policy that a member may submit an appeal verbally or in writing within 60 calendar days after an adverse benefit decision. • The Utilization Review Manual incorrectly listed the timeframe for filing an appeal as 180 days. *Quality Improvement Plan: Correct the errors identified in Healthy Blue's Provider Manual, Member Handbook, the Utilization Review Manual, and in Policy MCD-AP-10, Member Appeals Process, related to procedures for filing an appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Policy MCD-AP-10, Member Appeals Process, Member Handbook, and the Provider Manual describe the timeliness guidelines for processing appeals. The issues regarding the timeliness for notification and resolution of an appeal are as follows: • Policy MCD-AP-10, Member Appeals Process, the Extension Notification letter template, the Provider Manual, and the Member Handbook include the requirements for requesting an extension for Standard Appeals. However, the Member Handbook, the Extension Notification letter template, and Policy MCD-AP-10, Member Appeals Process, do not include the extension requirements for an expedited appeal request. • The Provider Manual does not include the contractual requirement to give the member prompt oral notification if Healthy Blue requests an extension. • CarelonRx Policy RX-URA-04, Appeals Process_Medicaid, does not provide the contractual requirement for notifying the member if a request for expedited appeal resolution is denied. • Healthy Blue's Customer Service Training Curriculum (page 330) does not mention the contractual requirement to give the member prompt oral notification if a request for expedited appeal resolution is denied. • The CarelonRx Policy RX-URA-07, External Appeal_Medicaid, is not specific regarding the timeframe for filing a State Fair Hearing. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						policy notes the timeframe as "no less than 90 days and no more than 120 calendar days from the date of the appeal resolution." The *SCDHHS Contract, Section 9.1.6.3.1.1,* notes this timeframe as no later than 120 calendar days. *Quality Improvement Plan: The deficiencies regarding the timeliness for notification and resolution of an appeal should be corrected.*
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.		X				Healthy Blue's Member Handbook, Provider Manual, and various letter templates describe the requirements for continuation of benefits for members while in the appeal process. However, Policy MCD-AP-10, Member Appeals Process, does not provide the guidelines of continuation of benefits process for members while in the appeal process. *Quality Improvement Plan: Update the appeal policy to include the continuation of benefits process for members while in the appeals process as required by SCDHHS Contract.*
2. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MCD-AP-10, Member Appeals Process, identifies that quarterly appeal logs will be submitted to South Care Department of Health and Human Services. Additionally, appeal quarterly reports are presented during the Service Quality Improvement Committee meetings wherein trends and opportunities for improvement are discussed.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
IV. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					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.
2. The MCO has processes to identify members who may benefit from case management.	X					Healthy Blue's Integrated Care Management Plan describes various referral sources such as health surveys, patient referrals, and claims data that aid in identifying potential members for case management services. Additionally, Heathy Blue Customer Advocates, Case Managers, and Utilization Managers may initiate a case referral as described Policy MCD-13, Case Management Referral.
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Healthy Blue's Medicaid Integrated Care Management Plan and various policies describe that once a referral is initiated, an initial assessment is conducted to include the member's status, clinical history, social determinants of needs, community resources, etc. to aid in care plan development. Care management activities such as community

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						referral, care coordination, member education, monitoring, etc. are conducted to address the members' needs. If there are specialized needs identified, targeted case management is provided to members to ensure there is no duplication of services provided and that the member is receiving the most appropriate level of care as described in Policy MCD-CM 14, Targeted Case Management Identification and Referral of Eligible Members.
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					
6. Care Transitions activities include all contractually required components.						
6.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Healthy Blue's Integrated Care Management Plan, Policy MCD-CM 19, Transition of Care for Members Coming From Another MCO or FFS, Policy MCD-20, Transition To Other Care for Members Disenrolling, and Policy MCD-CM 18, Transition and Continuity of Care Current Provider Terminated with Plan, outline the transitional of care process for members across health settings, during disenrollment, or enrollment.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					
IV E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.	X					Annually, trend reports will be analyzed by Healthy Blue to aid in detecting patterns of over-utilization and under-utilization of services that may include benchmarks such as emergency room utilization, claims data, etc. to aid in development of quality improvement measures as described in the health plan's Medicaid Integrated Care Management Plan and Policy MCD-UM 22, Under and Over Utilization of Services.

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 this review, Healthy Blue reported twelve delegation agreements, as shown in *Table 18: Delegated Entities and Services*.

Table 18: 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

All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Policy MCD-CP 11, Delegated Vendor Management and Oversight, describes the processes for oversight and monitoring of all delegates.

Prior to delegation, the Quality Management/Accreditation and Compliance departments are responsible for conducting pre-delegation assessments. This process requires the potential delegate to submit documentation supporting its ability to successfully perform the delegated functions and/or services, in accordance with applicable federal and *SCDHHS Contract* requirements.

For this Readiness Review, CarelonRx and National Imaging Associates (NIA) were subject to a pre-delegation assessment.

In October 2021, NIA underwent a compliance audit. This audit focused on the requirements related to compliance and included a review of contract documents, monthly OIG/GSA screenings, program descriptions, policies, procedures, and training requirements. This audit did not include the monthly monitoring/screenings required by SCDHHS. Healthy Blue confirmed this requirement will be added to the compliance audits. The results of this audit found no areas needing corrections. In September 2023, a pre-delegation assessment was conducted to assess NIA's ability to manage the utilization of some imaging services. The assessment included a review of utilization management policies and procedures, and the Utilization Management Program Description. NIA was found in compliance with all requirements.

CarelonRx underwent a pre-delegation audit in May 2023 and a pre-delegation compliance audit in June 2023. The pre-delegation audit was conducted in May to evaluate the entity's ability to perform the delegated activities prior to delegation. The audit included a review of CarelonRx's policies, procedures, and program descriptions. CarelonRx was found to be in compliance with all requirements.

A pre-delegation compliance program audit was conducted for CarelonRx in June 2023. This audit included a review of policies, procedures, standards of conduct, compliance program trainings, routine screenings, and validation of oversight of any identified subdelegated entities. This audit found CarelonRx met all performance and compliance requirements.

For the credentialing delegates, copies of the annual audits conducted for AnMed Health, HCA Physicians Services Group, Medical University of South Carolina, Prisma Health, Roper St. Francis Physician's Network, SC Department of Mental Health, Self Regional Healthcare, Spartanburg Health/Regional Health Plus, and VSP Vision Care were provided. The pre-delegation audit was provided for Tenet (HCS Physicians). The documentation confirmed annual oversight is conducted and any identified issues were documented.

Regular oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports. The contract/business owner is responsible for monitoring the timely and accurate submission of all required reports from the delegated vendor to Healthy Blue and presenting reports to the Compliance Committee for review. Corrective action plans are issued to resolve potential areas of non-compliance or to address unsatisfactory performance.

Figure 6: Delegation Findings

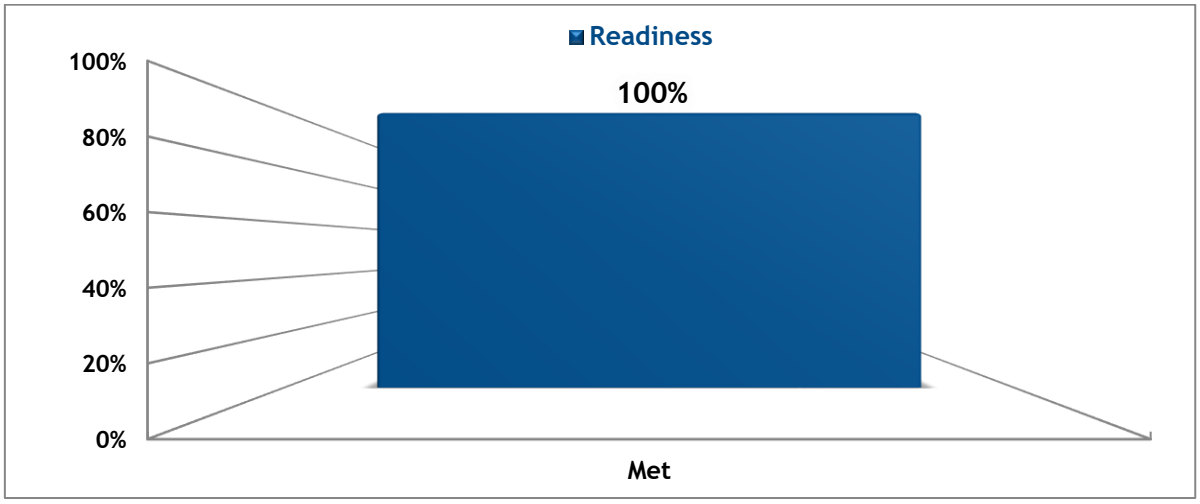


Table 19: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Prior to delegation, the Quality Management/Accreditation and Compliance departments are responsible for conducting pre-delegation assessments. This process requires the potential delegate to submit documentation supporting its ability to successfully perform the delegated functions and/or services, in accordance with applicable federal and SCDHHS Contract requirements.			✓
Regular oversight and monitoring activities are conducted for all delegated vendors through the review of relevant monthly, quarterly, and annual reports.	✓		

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VI. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Healthy Blue delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include utilization management, pharmacy services and credentialing. For this review, Healthy Blue reported twelve delegation agreements.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Prior to delegation, the Quality Management/Accreditation and Compliance departments are responsible for conducting pre-delegation assessments. This process requires the potential delegate to submit documentation supporting its ability to successfully perform the delegated functions and/or services, in accordance with applicable federal and *SCDHHS Contract* requirements. For this Readiness Review CarelonRx and National Imaging Associates (NIA) were subject to a pre-delegation assessment. The results of the assessments found both delegates met all performance and compliance requirements. For the credentialing delegates, copies of the annual audits conducted, and monthly monitoring was provided. The documentation confirmed annual oversight is conducted and any identified issues were documented.

Attachments

Attachment 1: Initial Notice and Materials Requested for Desk Review

The Carolinas Center *for* Medical Excellence
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

July 18, 2023

Mr. Tim Vaughn
President and COO
Healthy Blue
4101 Percival Road
Columbia, SC 29229

Dear Mr. Vaughn:

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

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), virtual onsite and will address all contractually required services. The CCME EQR team plans to conduct the virtual onsite at on **October 10, 2023**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **August 14, 2023.**

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

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review (Readiness Review)

MATERIALS REQUESTED FOR DESK REVIEW

1. A description of the managed care organization (MCO), including any lines of business in addition to South Carolina Medicaid managed care.

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

3. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. If this is a corporate organizational chart, please identify those persons who will have responsibility for overseeing South Carolina Medicaid activities and where they will be located.

4. Current staffing levels and changes projected for increasing enrollment.

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

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

7. The Quality Improvement work plan for 2023/2024 or a sample of the proposed workplan.

8. Planned format for documenting all Performance Improvement Projects (PIPs). This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e., analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, barriers to improvement, results, etc…).

9. Planned methodology for collecting and reporting performance and quality measure data.

10. A committee matrix for all planned committees. For each committee, please include the following:
    a. A copy of the committee charter. Include the committee's responsibilities, meeting frequency, and the required voting quorum.
    b. Membership list and indicate which members are voting members. Include the professional specialty of any non-staff members.
    c. The planned format for recording meeting minutes.

11. Minutes for any committee meeting(s) that has taken action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

12. Plans for data collection for the purposes of monitoring the utilization (over and under) of heath care services.

13. A copy of staff handbooks/training manuals, orientation and educational materials. Please include training schedules and/or workplans.

14. Copies of scripts to be used by Member Services Representatives and/or Call Center personnel.

15. A copy of the member handbook and statement of the member bill of rights and responsibilities and notice of privacy practices if not included in the handbook.

16. All information to be supplied as orientation to new members.

17. Planned methodology for assessing member satisfaction.

18. Samples and/or descriptions of planned member educational materials and activities, including any newsletters or mass mailings.

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

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

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

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

These materials:

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

Attachment 2: Materials Requested for Onsite Review

Readiness Review 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Updated Org. Chart or a list of vacant positions filled since the desk materials were received.
3. A copy of the “Our Values” document.