2022 External Quality Review

SOUTH CAROLINA SOLUTIONS

Submitted: August 22, 2022

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

Table of Contents

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 2022 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by SC Solutions (Solutions) since the 2021 Annual Review.

The goals and objectives of the review are to:

- Determine if Solutions is following service delivery requirements as mandated in the organization's contract with SCDHHS and in the federal regulations
- Evaluate the status of deficiencies identified during the 2021 EQR and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted primary care case management services are being delivered and are of good quality

The process CCME used for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review includes a desk review of documents and files and a one-day virtual onsite visit.

Summary and Overall Findings

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

- Coordination and Continuity of Care *(§ 438.208)*
- Confidentiality *(§ 438.224)*
- Health Information Systems *(§ 438.242)*
- Quality Assessment and Performance Improvement Program *(§ 438.330)*

To access Solutions' compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into four areas. The following is a high-level summary of the review results for those areas.

Administration:

42 CFR § 438.224, 42 CFR § 438.242

Solutions maintains written policies and procedures for all areas of the company. Policies indicate the policy effective date, review dates, the date of the most recent revision, and identification of the approval activity. The Compliance Department maintains a master list of all policies and facilitates the annual review process. Leadership for each Business Unit is responsible for disseminating policies to staff and overseeing implementation of the policies.

Solutions is a subsidiary organization of Community Health Solutions of America (CHS). Dr. Barbara Freeman, Chief Medical Officer (CMO), is responsible for the administrative oversight of day-to-day activities. The organizational chart indicated Dr. Freeman is also listed as the Executive Director and Interim Medical Director; thus, she is serving in three different roles. During onsite discussion, staff indicated they were actively recruiting a Medical Director and expect to fill the position within the next month. Staff also reported the Executive Director's position was being eliminated.

Three full-time Directors of Care Coordination are responsible for the onsite Care Coordinators. A Care and Durable Medical Equipment (DME) Advocate Manager is responsible for the Care Advocates, DME Advocates, and the Parent Advocate. Three vacant positions were noted on the organizational chart; however, staff reported those positions had been filled.

All employees are screened upon hire to determine if they have been excluded from participation in any state or federal programs. Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks, indicates the Human Resources Department performs the initial exclusions review and the Compliance Department conducts monthly exclusion monitoring. CCME reviewed a sample of personnel files and found the initial screenings had been conducted. However, the files lacked evidence of the monthly screenings. Solutions provided additional screenshots of the monthly queries to show the exclusion screenings were conducted. For the review period of June 2021 through May 2022, none of the personnel files contained 12 months of screenings.

Other findings in the personnel files included a lack of Tuberculin skin testing results for clinical staff and evidence of Health Insurance Portability and Accountability Act (HIPAA) and Compliance training. Solutions indicated that clinical staff were not conducting face-to-face visits due to COVID-19, so the Tuberculin skin testing was not required per the Appendix K Waiver. The roster of employees completing the required trainings for compliance and HIPAA was provided.

All staff, including remote and onsite staff, receive HIPAA and information security training prior to being allowed access to Protected Health Information (PHI). Through continued education, all employees receive training at least annually.

The Compliance Plan details the Fraud Waste and Abuse guidelines and mentioned the Code of Ethical Conduct that applies to all employees. However, the Compliance Plan does not specifically outline or list the standards of conduct employees are expected to follow.

Policies and procedures are in place for Solutions to address data, system, and information security and access management. The desk material review found that the organization's physical security procedures adhere to industry best practices. Solutions has an extensive Continuity of Operations Plan, and based on the version history, the plan is regularly reviewed and updated.

Provider Services:

Solutions' provider network is currently closed but the organization anticipates reopening the network to new providers soon. When new providers are enrolled, orientation is conducted within 30 days and covers a broad range of topics to ensure providers understand the program and can care for Medically Complex Children Waiver (MCCW) participants.

The Provider Manual is posted on Solutions' website and provides comprehensive information including key contact information and program goals, processes, and requirements. Free language services are available, and the Provider Manual includes both toll-free telephone and TTY numbers to access these language services, which include qualified verbal and sign language interpreters. Member materials are also available in alternate formats, such as large print, braille, audio, etc.

Solutions staff reported during the onsite visit that no face-to-face ongoing provider education is currently being conducted.

Quality Improvement:

42 CFR §438.330

Solutions' 2022 Strategic Quality Plan provides a description of the health plan's approach to quality management and performance improvement. Solutions' CMO is primarily responsible for oversight of the quality program including clinical performance outcome monitoring. The Strategic Quality Plan indicated the document contained appendices. During the onsite visit, staff explained the Strategic Quality Plan did not have appendices.

Solutions develops a Quality Work Plan annually. The 2021 and 2022 Work Plans submitted for review included the projects/activities, interventions, start dates, estimated completion dates, responsible parties, and quarterly updates. During the previous EQR, CCME recommended Solutions update the estimated completion dates. This recommendation was completed by Solutions, and the estimated completion date was included for each activity.

Solutions has three projects underway. Topics for those projects included: SCS Onsite Quality Program Coordination Implementation, Enhanced Provider Network Program Modifications, and Update/Create a Policy for Person-Centered Service Plan. The project documents lacked details regarding the selected study question and aim for the projects. Clearly defined measurable indicators were not included in the project documents. The baseline measurement, specific goal(s), method for data collection, identified barriers, and interventions to address those barriers were also not included. The project documents should be revised to clearly address the missing information. Quarterly data was documented for the SCS Onsite Quality Program Coordination Implementation project with a narrative explanation. CCME suggests the data collected for the projects be displayed as a graph along with the narrative analysis.

The Compliance & Quality Management Committee (CQMC) is the local committee responsible for oversight of all aspects of the Quality Improvement (QI) Program. The committee is chaired by the CMO, and voting members include the Chief Compliance Officer, Manager of Medical Informatics, Quality Coordinator, and other team leads. The committee meets no less than quarterly. In 2021, the committee only met in the first and third quarters. For 2022, the committee is on track for meeting quarterly.

Solutions evaluates the overall effectiveness of the QI Program and reports this assessment to the CQMC. The Quality and Performance Improvement 2021 Annual Report included the results and/or updates of all activities conducted in 2021.The program evaluation was sent to the CQMC and the Board of Directors for review and approval.

Although Solutions met all the requirements in the Quality Improvement area, the documentation in the Strategic Quality Plan and the project documents showed weaknesses.

Care Coordination/Case Management:

42 CFR § 208

The Medically Complex Children Waiver Program Description provides an overview of the organization, program structure and oversight, goals, and objectives. Program policies provide details and processes to guide staff that conduct daily Care Coordination and Case Management activities. Solutions continues to operate under the Appendix K Waiver

due to the Federal Health Emergency for COVID-19. Therefore, all contacts with participants, responsible parties, and providers continue to be conducted by telephone.

Issues noted when reviewing Care Management policies included lack of a policy addressing discharge planning for participants who are admitted to a hospital and lack of detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant in the Child Protective Services policy and procedure. Care Management files were thorough and included all necessary documentation. One minor issue was identified related to undated Growth and Development Assessment forms in two files.

Quality Improvement Plans and Recommendations from Previous EQR

For the previous EQR in 2021, one standard was scored as "Partially Met." Solutions did not have documented processes for developing, monitoring, evaluating, and coordinating Person-Centered Service Plans. Following the 2021 EQR, Solutions submitted a Quality Improvement Plan to address the deficiency identified. CCME reviewed and accepted the Quality Improvement Plan on March 2, 2022.

During the current EQR, CCME assessed the degree to which Solutions implemented the actions to address this deficiency and found the Quality Improvement Plan was appropriately addressed and implemented.

Conclusions

For the current EQR, Solutions met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*.

Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards provides an overall snapshot of Solutions' compliance scores specific to each of the three *Subpart D* and QAPI standards above.

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

Standards	Category	Total Number of Standards	Number of Standards Scored as "Met"	2022 Overall Score
Section IV. Care Coordination/Case Management	• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	15	13	87%

Standards	Category	Total Number of Standards	Number of Standards Scored as "Met"	2022 Overall Score
Administration, Section I. E. - Confidentiality	• Confidentiality *(§ 438.224)*	1	1	100%
Administration, Section I. F. Data Systems/Security	• Health Information Systems *(§ 438.242, § 457.1233)*	2	2	100%
Quality Improvement Section	• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	7	7	100%

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

As noted in the table above, two standards in the Care Coordination/Case Management section did not receive a "Met" score. These were related to missing and/or insufficient information in policies about discharge planning for participants who are admitted to a hospital and the process for reporting suspected abuse, neglect, or exploitation of a participant.

Table 2: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2021 review. For 2022, 58 of the 61 standards received a score of "Met." Two standards were scored as "Partially Met" and one standard was scored as "Not Met."

Table 2: Scoring Overview

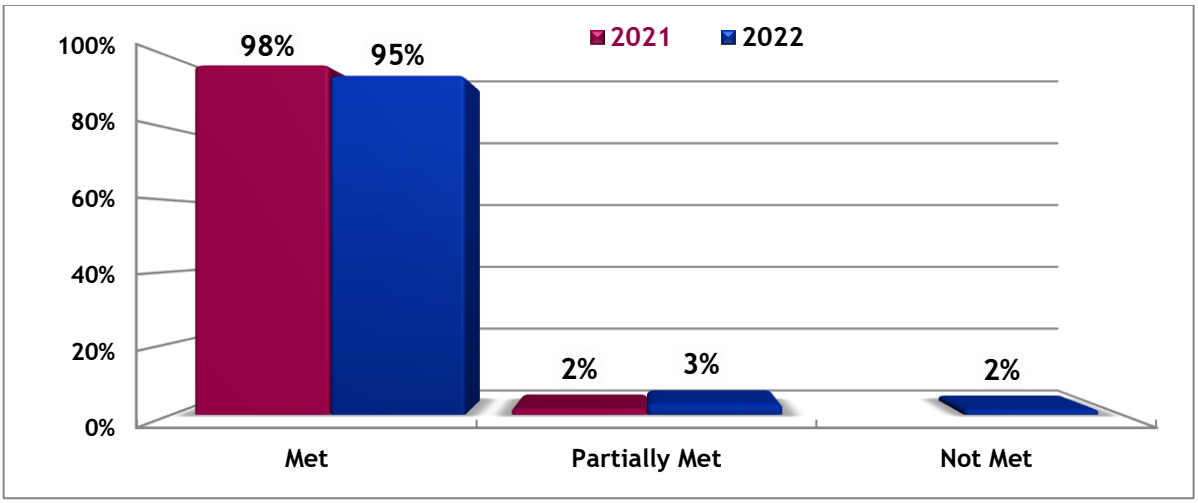
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	34	0	0	0	0	34	100%
2022	33	1	0	0	0	34	97%
Provider Services							
2021	5	0	0	0	0	5	100%
2022	5	0	0	0	0	5	100%
Quality Improvement							
2021	7	0	0	0	0	7	100%
2022	7	0	0	0	0	7	100%
Care Coordination/Case Management							
2021	14	1	0	0	0	15	93%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2022	13	1	1	0	0	15	87%
Totals							
2021	**60**	**1**	**0**	**0**	**0**	**61**	**98%**
2022	**58**	**2**	**1**	**0**	**0**	**61**	**95%**

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

The 2022 Annual EQR shows that Solutions achieved "Met" scores for 95% of the standards reviewed. As the following chart indicates, 3% of the standards were scored as "Partially Met" and 2% were scored as "Not Met." The following chart provides a comparison of the current review results to the 2021 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 3: Evaluation of Quality

Strengths Related to Quality
• Policies and procedures were found to be reviewed in a timely manner. • For information systems, backup testing frequency (weekly) surpasses the test frequency typically practiced in the industry. • The Quality Work plans for 2021 and 2022 were complete. • Information provided to newly enrolled participants is comprehensive and covers freedom of choice; PCSPs; participant rights and responsibilities; non-compliance; appeals; community resources; reporting fraud, waste, and abuse; Child Protective Services, and more. • Files reflected that staff document multiple attempts to contact participants before sending "Unable to Contact" notices. No participants are currently being disenrolled due to the inability to contact.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• The Chief Medical Officer was also acting as the Executive Director and Interim Medical Director.	• Recommendation: Continue the recruiting efforts to fill the Medical Director position. Also, determine if the vacant Executive Director position will be filled.
• Personnel files lacked evidence of the monthly exclusion screenings as required by Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks.	• Quality Improvement Plan: Ensure that steps are taken to conduct monthly exclusion monitoring of employees to align with Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting.
• Solutions staff reported during the onsite visit that no face-to-face ongoing provider education is currently being conducted. Staff reported that the Provider Manual was updated in late 2021, and providers were informed of the revisions. The current Provider Manual is posted on Solutions' website.	• Recommendation: Consider alternate methods/forums for conducting ongoing provider education, such as through webinars, virtual meetings, etc.
• The 2022 Strategic Quality Plan contained references to appendices that were not included in the document.	• Recommendation: Correct the Strategic Quality Plan to remove the references to appendices.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Committee approval for the 2022 Strategic Quality Plan and the Quality and Performance Improvement 2021 Annual Report was not documented in the committee minutes.	• Recommendation: Update the CQMC minutes and add an addendum regarding the electronic review and approval of the 2022 Strategic Quality Plan and the Quality and Performance Improvement 2021 Annual Report that occurred outside of the scheduled committee meeting.
• The project documents lacked details regarding the selected study question and aim for the projects. Clearly defined measurable indicators, the baseline measurement, specific goal(s), the method for data collection, identified barriers, and interventions to address those barriers were also not included.	• Recommendation: Revise the project documents to address the missing information.
• A policy addressing discharge planning for participants who are admitted to a hospital has not been developed.	• Quality Improvement Plan: Develop and implement a policy and procedure that details the roles and responsibilities of Care Coordination staff in discharge planning processes for currently enrolled participants who are admitted to a hospital.
• Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, does not provide detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant or actions taken after filing a report.	• Quality Improvement Plan: Revise Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, to include detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant, and any actions taken/follow-up after a report is made.
• Two Care Coordination files contained undated Growth and Development Assessment forms.	• Recommendation: Ensure all Growth and Development Assessment forms are signed and dated at the time of completion.

METHODOLOGY

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

On May 30, 2022, CCME sent notification to Solutions that the annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Solutions to ask questions regarding the EQR process and the requested desk materials. After receiving the notification and desk materials list, Solutions requested an extension for submitting the desk materials and to postpone the onsite date. SCDHHS and CCME approved this request.

The review consisted of two segments. The first was a desk review of materials and documents received from Solutions on June 27, 2022 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, provider educational materials, and the Quality Improvement and Case Management/Care Coordination Programs. Also included in the desk review was a review of personnel and case management files.

The second segment was a virtual onsite review conducted on August 3, 2022. The onsite visit focused on areas not covered in the Desk Review or needing clarification. The onsite activities included an entrance conference, interviews with Solutions 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 Solutions and SCDHHS. Strengths, Weaknesses, and Recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 2*).

A. Administration

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

Solutions maintains written policies and procedures for all company areas. Policies include the effective date, review dates, the date of the most recent revision, and identification of the approval activity. The Compliance Department maintains a master list of all policies and oversees the annual review process. Each Senior Business Unit's leadership is responsible for disseminating policies to staff and overseeing implementation of the policies. The processes for policy management are included in Policy CHS.ADM.ALL.01.01, Policy and Procedure Management. Staff have access to the policies on two shared drives and on Healthicity. This allows staff easy access via a virtual private network (VPN) and the Healthicity website.

Solutions is a subsidiary organization of Community Health Solutions of America. Dr. Barbara Freeman, Chief Medical Officer (CMO), is responsible for the administrative oversight of day-to-day activities. The organizational chart indicates Dr. Freemen is also listed as the Executive Director and Interim Medical Director. It was concerning that Dr. Freeman was serving in three different roles. Staff indicated they were actively recruiting a Medical Director and the Executive Director's position was being eliminated.

Three full-time Directors of Care Coordination are responsible for the onsite Care Coordinators. The Care and DME Advocate Manager is responsible for the Care Advocates, DME Advocates, and Parent Advocates. Three vacant positions were noted on the organizational chart, and staff reported those positions had been filled.

Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing, provides the process for verification of staff qualifications and screenings. The policy discusses the verification of clinical licenses, CPR certification, TB Test results, and background checks. Policy HR 01.41, Background Check Policy and Procedure (Non-Clinical Positions), addresses the criminal background checks for non-clinical staff.

All employees are screened upon hire to determine if they have been excluded from participation in any state or federal programs. Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks, indicates the Human Resources Department performs the initial exclusions review and the Compliance Department performs monthly exclusion monitoring. CCME reviewed a sample of personnel files and found the initial screenings had been conducted. However, the files lacked evidence of the monthly screenings. Solutions provided additional screenshots shots of the monthly queries to demonstrate the exclusion screenings were conducted. For the review period of June 2021 through May 2022, none of the files contained 12 months of screenings.

Other findings in the personnel files included a lack of Tuberculin Purified Protein Derivative (PPD) testing results for clinical staff and evidence of HIPAA and Compliance training. Solutions indicated that as clinical staff did not conduct face-to-face visits due to COVID-19, the PPDs were not required. The roster of employees completing the required HIPAA and Compliance training was provided.

All staff, including remote and onsite staff, receive HIPAA and information security training prior to being allowed access to Protected Health Information. Through continued education, all employees receive training at least annually.

The Compliance Plan details the Fraud, Waste, and Abuse guidelines and mentions the Code of Ethical Conduct that applies to all employees. However, the Compliance Plan does not specifically outline or list the standards of conduct employees are expected to follow.

Information Systems Capabilities

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

Policies and procedures are in place for Solutions to address data, system, and information security and access management. The review of Solutions' documentation found that the organization's physical security procedures adhere to industry best practices. Solutions has an extensive Continuity of Operations Plan and based on the version history, the plan is regularly reviewed and updated.

For the Administration section of this EQR, 97% of the standards were scored as "Met." There were issues in the personnel files that require correction. *Figure 2: Administration Findings* compares the 2021 score for the Administration section to the current year.

Figure 2: Administration Findings

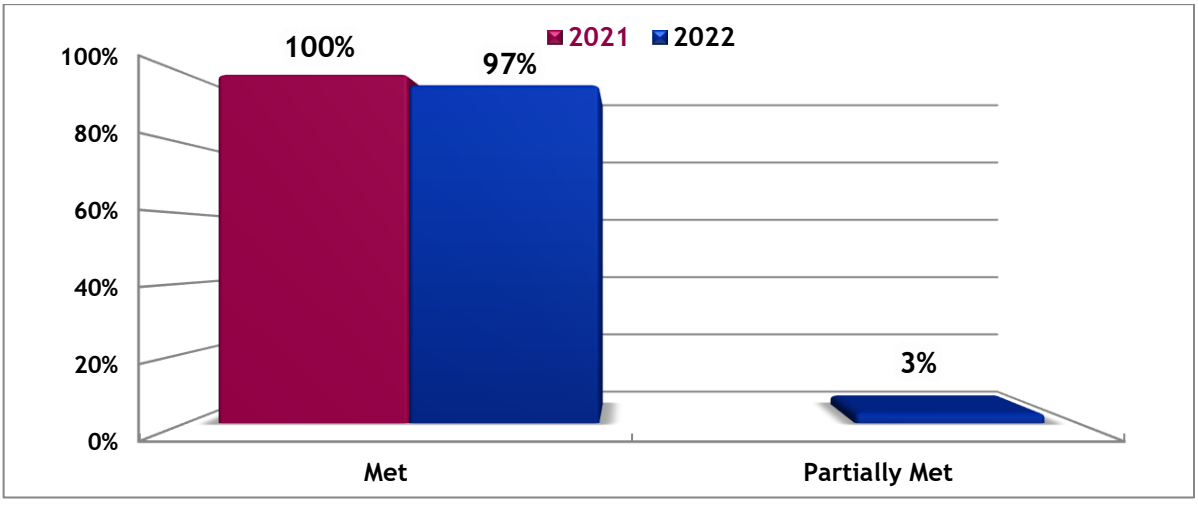


Table 4: Administration Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Organizational Chart / Staffing	Employee personnel files demonstrate compliance with contract and policy requirements	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Policies and procedures were found to be reviewed in a timely manner.
- For information systems, backup testing frequency (weekly) surpasses the test frequency typically practiced in the industry.

Weaknesses

- The Chief Medical Officer was also acting as the Executive Director and Interim Medical Director.
- Personnel files lacked evidence of the monthly exclusion screenings as required by Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks.

Quality Improvement Plans

- Ensure that steps are taken to conduct monthly exclusion monitoring of employees to align with Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting.

Recommendations

- Continue the recruiting efforts to fill the Medical Director position. Also, determine if the vacant Executive Director position will be filled.

B. Provider Services

The Provider Services review included policies and procedures, provider training materials, the Provider Manual, and Solutions' website.

Onsite discussion confirmed that Solutions' provider network is currently closed, but the organization shared that it anticipates reopening the network to new providers soon. Generally, new provider orientation is conducted within 30 days of contracting and covers a broad range of topics for providers to understand the program and care for Medically

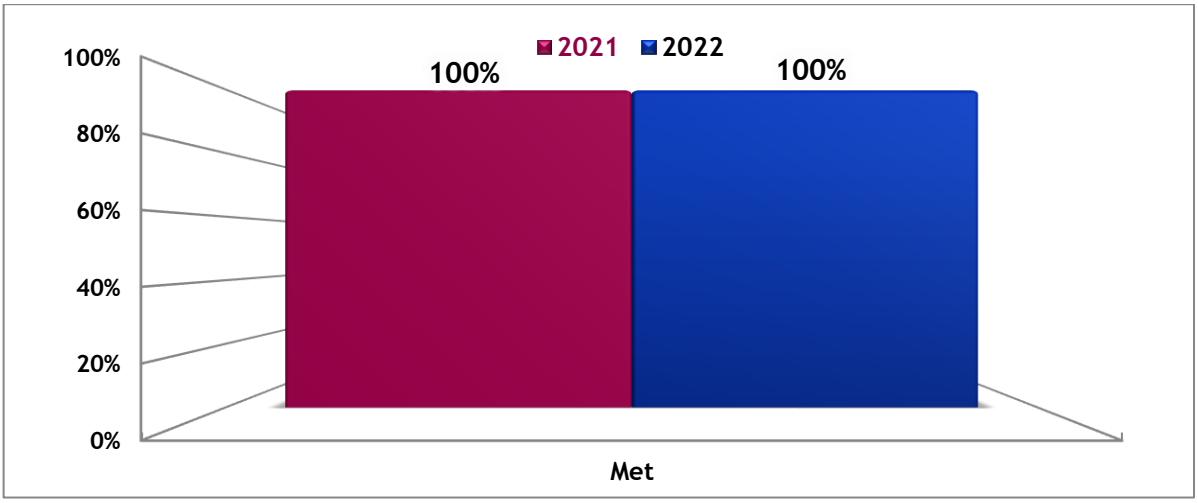
Complex Children Waiver (MCCW) participants. Topics covered in provider orientation are specified in policy.

The Provider Manual is posted on Solutions' website and serves as a ready resource for network providers. It includes key contact information, goals of the MCCW, program processes and requirements, and information about the role of the provider in caring for MCCW participants. The Provider Manual also addresses requirements for medical record documentation, retention, and storage. Free language services are available, and the Provider Manual includes both toll-free telephone and TTY numbers to access these language services, which include qualified verbal and sign language interpreters. Member materials are also available in alternate formats, such as large print, braille, audio, etc.

Solutions staff reported during the onsite visit that no face-to-face ongoing provider education is currently being conducted. However, the Provider Manual was updated in late 2021, and providers were informed of the revision. CCME recommended that the organization consider alternate forums to conduct provider education, such as webinars or virtual meetings.

As illustrated in *Figure 3: Provider Services Findings*, 100% of the standards in the Provider Services section were scored as "Met."

Figure 3: Provider Services Findings



Weaknesses

- Solutions staff reported during the onsite visit that no face-to-face ongoing provider education is currently being conducted. Staff reported that the Provider Manual was updated in late 2021, and providers were informed of the revisions. The current Provider Manual is posted on Solutions' website.

Recommendations

- Consider alternate methods/forums for conducting ongoing provider education, such as through webinars, virtual meetings, etc.

C. Quality Improvement

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

Solutions' 2022 Strategic Quality Plan provides a description of the health plan's approach to quality management and performance improvement. The Strategic Quality Plan describes the program's goals, objectives, structure, and resources. Solutions' Chief Medical Officer is primarily responsible for oversight of the quality program, including clinical performance outcome monitoring. It was unclear if the Strategic Quality Plan had been approved. The note in the footer indicated the document was approved by the Compliance & Quality Management Committee (CQMC) on June 27, 2022. However, the CQMC did not meet on that date. Also, page three indicates the document contained appendices. During the onsite visit, staff explained the Strategic Quality Plan did not have appendices and had been sent to the CQMC via email for review and approval.

Solutions develops a Quality Work Plan annually. CCME requested and received the 2021 and 2022 Quality Work Plans. The Quality Work Plans included the projects/activities, interventions, start dates, estimated completion dates, responsible parties, and quarterly updates. During the previous EQR, CCME recommended Solutions update the estimated completion dates. This recommendation was completed by Solutions, and the estimated completion date was included for each activity.

Solutions has three projects underway. Topics for those projects included: SCS Onsite Quality Program Coordination Implementation, Enhanced Provider Network Program Modifications, and Update/Create a Policy for Person-Centered Service Plan. The project documents lacked details regarding the selected study question and aim for the projects. Clearly defined measurable indicators were not included in the project documents. The baseline measurement, specific goal(s), the method for data collection, identified barriers, and interventions to address those barriers were also not included. The project documents should be revised to clearly address the missing information. Quarterly data was documented for the SCS Onsite Quality Program Coordination Implementation project with a narrative explanation. CCME suggests the data collected for the projects be displayed as a graph along with the narrative analysis.

Solutions' Corporate Board of Directors is ultimately responsible for the Quality Improvement (QI) Program. The Board is responsible for the initiation of the QI Program and direct its implementation throughout the organization. The CQMC is the local committee responsible for oversight of all aspects of the QI Program. The committee is

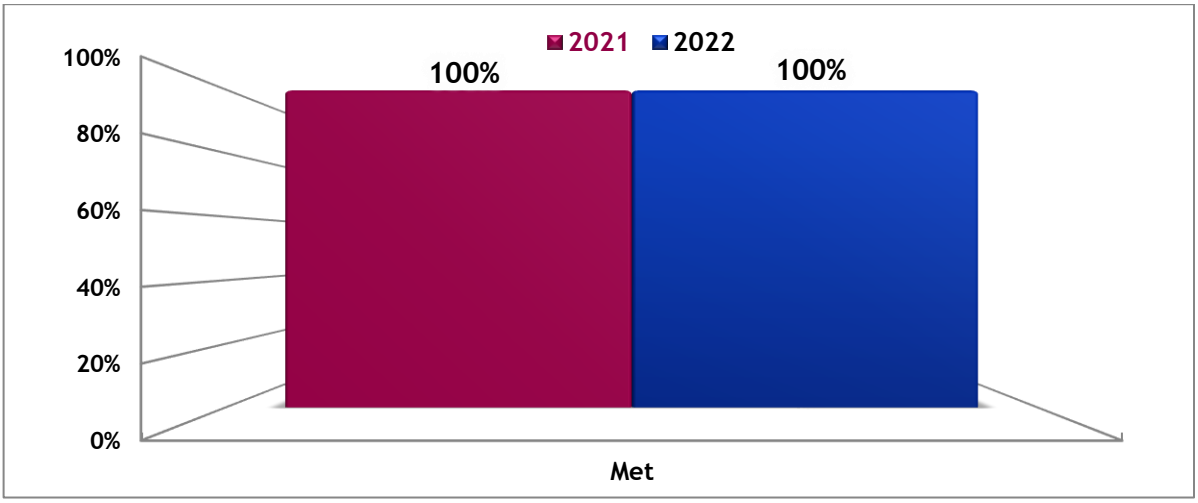
chaired by the CMO. Voting members include the Chief Compliance Officer, Manager of Medical Informatics, the Quality Coordinator, and other team leads.

According to the Strategic Quality Plan, the CQMC meets no less than quarterly. The minutes received indicated that for 2021, the committee met in the first and third quarters. Solutions confirmed the meetings scheduled for the second and third quarters had to be cancelled. For 2022, the committee is on track for meeting quarterly. The minutes of the meetings held in the first and second quarter of 2022 were provided.

Solutions evaluates the overall effectiveness of the QI Program and reports this assessment to the CQMC. The Quality and Performance Improvement 2021 Annual Report included the results of and/or updates for all activities conducted in 2021. The program evaluation also included the goals for 2022. The program evaluation was sent to the CQMC and the Board of Directors for review and approval.

Although Solutions met all the requirements in the Quality Improvement area, the documentation in the Strategic Quality Plan and the project documents showed weaknesses.

Figure 4: Quality Improvement Findings



Strengths

- The Quality Work plans for 2021 and 2022 were complete.

Weaknesses

- The 2022 Strategic Quality Plan contained references to appendices that were not included in the document.

- Committee approval for the 2022 Strategic Quality Plan and the Quality and Performance Improvement 2021 Annual Report was not documented in the committee minutes.
- The project documents lacked details regarding the selected study question and aim for the projects. Clearly defined measurable indicators, the baseline measurement, specific goal(s), the method for data collection, identified barriers, and interventions to address those barriers were also not included.

Recommendation

- Correct the Strategic Quality Plan to remove the references to appendices.
- Update the CQMC minutes and add an addendum regarding the electronic review and approval of the 2022 Strategic Quality Plan and the Quality and Performance Improvement 2021 Annual Report that occurred outside of the scheduled committee meeting.
- Revise the project documents to address the missing information.

D. Care Coordination/Case Management

42 CFR § 208

Solutions' Executive Director/Chief Medical Officer reports to the corporate Board of Directors, oversees program operations, and is responsible for ensuring the goals and objectives of SCDHHS and Solutions are aligned. The role of the Medical Director, a position that is currently vacant and being filled on an interim basis by the CMO, is to provide clinical oversight and decision making. The Directors of Care Coordination oversee the daily activities of Care Coordinator staff.

Solution's Medically Complex Children Waiver Program Description provides an overview of the organization, program structure and oversight, and goals and objectives. Program policies provide details and processes to guide staff that conduct daily Care Coordination and Case Management activities. Solutions continues to operate under the Appendix K Waiver due to the Federal Health Emergency for COVID-19. Therefore, all contacts with participants, responsible parties, and providers continue to be conducted virtually, generally by telephone. Participants and caregivers continue to be included in review and revisions of Person Centered Service Plans (PCSPs).

A review of program policies and other documentation revealed that, overall, program requirements and processes are well documented. It was confirmed that the Care Planning/Monthly Summary Report policy was revised to clearly document the process used to regularly update and evaluate PCSPs according to requirements in the SCDHHS Contract. This was a Quality Improvement Plan from the previous EQR. See *Table 5*.

Table 5: Previous Care Coordination/Case Management QIP

Standard	EQR Comments
IV. Care Coordination/Case Management	
2.9 Process to regularly update and evaluate the Person Centered Service Plans on an ongoing basis	Documentation in Policy CHS.CM.MCCW.01.08, Care Planning/Monthly Summary Report, and in the Provider Manual regarding Person Centered Service Plans (PSCP) is very minimal and confusing. During the onsite, Solutions staff reported that the Care Coordinators review the PCSPs during every monthly call and create new PCSPs during the annual re-evaluation. The new PCSP is signed by a SCDHHS representative. However, CCME could not identify documentation of Solutions' process for monitoring, updating, or evaluating PCSPs on a regular basis. *Quality Improvement Plan: Clearly document, in a policy or other document, the process used to regularly update and evaluate PCSPs, according to requirements in the Medicaid HCBS Waiver Services Care Coordination Contract, Appendix A, Section D (1) (b).*
Solutions' Response: Please see the highlighted area of the attached policy CHS.CM.MCCW.01.08, which states that the service plan is reviewed twice yearly (at the semi annual and annual reviews), and as needed, for short and long term goals. Additionally, the Care Coordinator requests review and approval of the PCSP by SCDHHS twice yearly after the semi annual and annual visits are completed, and as needed (see highlighted areas of attached policy CHS.CM.MCCW.02.01. Also, attached is our monthly summary report which is reviewed and updated monthly with contacts with responsbile parties. See the highlighted area, where the Care Coordinator can indicate if the service plan was reviewed during that monthly contact. We also plan to draft a new stand alone policy specifically for the Person Centered Service Plan during our yearly policy review in May for clarity.	

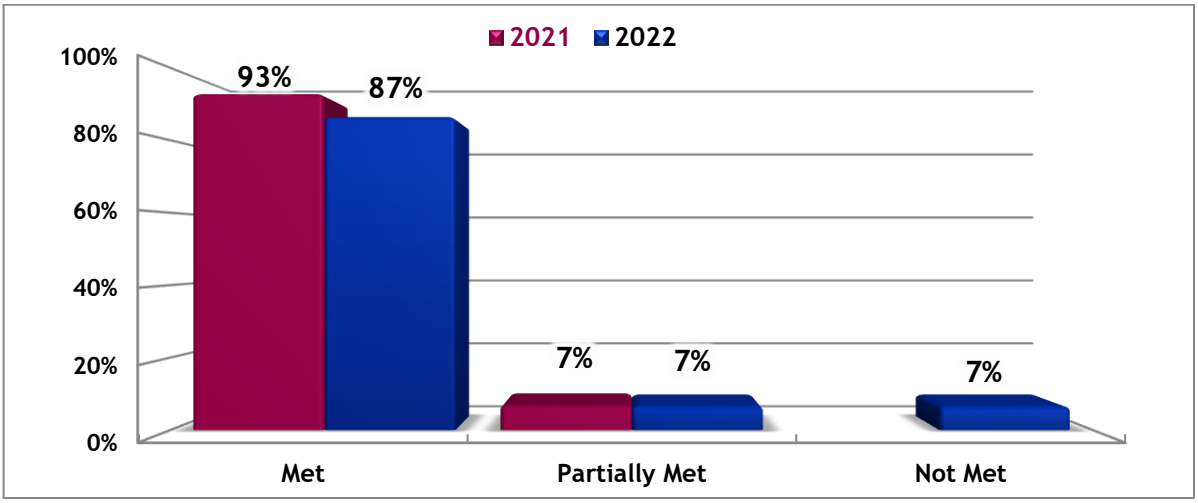
However, the following issues were noted during review of Solutions' policies during the current EQR:

- A policy addressing discharge planning for participants who are admitted to a hospital was not found. Solutions staff confirmed a policy has not been created for this topic, but stated Care Coordination staff are encouraged to access the electronic health record systems to which they have access (Prisma and MUSC) for discharge summaries, etc. Staff also stated Care Coordination staff work with hospital care management staff to ensure discharge needs are met.
- Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, does not provide detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant or actions taken after filing a report.

The review of a sample of Care Coordination files revealed only one minor issue: Two of the files had undated Growth and Development Assessment forms. Staff were cautioned to ensure all participant forms are dated.

As shown in *Figure 5: Care Coordination/Case Management Findings*, 87% of the standards for the section received a "Met" score, 7% received a "Partially Met" score, and 7% received a "Not Met" score.

Figure 5: Care Coordination/Case Management Findings



Totals may not equal 100% due to rounding

Table 6: Care Coordination/Case Management Comparative Data displays standards for which there was a change in score from the 2021 EQR to the 2022 EQR.

Table 6: Care Coordination/Case Management Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Care Coordination/ Case Management	Policies and procedures and/or the program description address the following: Process to regularly update and evaluate the Person-Centered Service Plan on an ongoing basis.	Partially Met	Met
Care Coordination/ Case Management	Processes for following up with participants admitted to the hospital and actively participate in discharge planning.	Met	Not Met

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
	Processes for reporting suspected abuse, neglect, or exploitation of a participant.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Information provided to newly enrolled participants is comprehensive and covers freedom of choice; PCSPs; participant rights and responsibilities; non-compliance; appeals; community resources; reporting fraud, waste, and abuse; Child Protective Services, and more.
- Files reflected that staff document multiple attempts to contact participants before sending "Unable to Contact" notices. No participants are currently being disenrolled due to the inability to contact.

Weaknesses

- A policy addressing discharge planning for participants who are admitted to a hospital has not been developed.
- Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, does not provide detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant or actions taken after filing a report.
- Two Care Coordination files contained undated Growth and Development Assessment forms.

Quality Improvement Plans

- Develop and implement a policy and procedure that details the roles and responsibilities of Care Coordination staff in discharge planning processes for currently enrolled participants who are admitted to a hospital.
- Revise Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, to include detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant, and any actions taken/follow-up after a report is made.

Recommendation

- Ensure all Growth and Development Assessment forms are signed and dated at the time of completion.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Tabular Spreadsheet

A. Attachment 1: Initial Notice, Materials Requested for Desk Review

May 26, 2022

Dr. Bobbie Freeman
SC Solutions
PO Box 1763
Columbia, SC 29202

Dear Dr. Freeman:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2022 External Quality Review (EQR) of South Carolina Solutions is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of the Medically Complex Children's Waiver program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services. The CCME EQR team plans to conduct the onsite visit via teleconference on **July 12th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **June 13, 2022.**

To help with submission of the desk materials, we have set-up a secure file transfer site to allow organizations 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 schedule an education session (via webinar) on how to utilize the file transfer. An opportunity for a conference call with your staff, to describe the review process and answer any questions, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosures
cc: SCDHHS

External Quality Review

MATERIALS REQUESTED FOR DESK REVIEW

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

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. If this is a corporate organizational chart, please identify those persons who are responsible for overseeing South Carolina Solutions activities. *From the organizational chart, we will randomly select personnel files to be submitted for review and provide a list of the file components needed.*

3. A description of any updates or changes in requirements disseminated by SCDHHS.

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

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

6. A copy of the current Compliance Plan or policies and procedures addressing compliance, fraud, waste, and abuse.

7. A description of the Quality Improvement, Care Coordination/Case Management Programs.

8. The Quality Improvement work plans for 2021 and 2022.

9. The most recent reports summarizing the effectiveness of the Quality Improvement, Care Coordination/ Case Management Programs.

10. A committee matrix for all 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.

11. Minutes of all meetings for all committees reviewing or taking action on SC Solutions-related activities from June 2021 to May 2022. 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. A complete list of all members enrolled in the care coordination/case management programs from June 2021 to May 2022. Please include open and closed case files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for care coordination or case management services. From these files we will randomly select specific files for review.

13. A copy of staff handbooks/training manuals, orientation and educational materials.

14. A copy of written information provided to new participants.

15. A copy of materials used for initial provider training/orientation.

16. A copy of any member and provider newsletters, educational materials, and/or other mailings.

17. A copy of the provider handbook or manual, if applicable.

18. A sample provider contract.

19. Please provide a completed Information Systems Capabilities Assessment (ISCA) form. Areas on the ISCA form not applicable to your organization maybe marked as N/A.

20. A copy of the Business Continuity/Disaster Recovery Plan.

21. A copy of the most recent disaster recovery or business continuity plan test results.

22. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.

23. A description of the data security policy with respect to email and PHI.

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at https://egro.thecarolinascenter.org**
- **submitted in the categories listed**

B. Attachment 2: Tabular Spreadsheet

CCME Data Collection Tool

Plan Name:	**SC Solutions**
Collection Date:	**2022**

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. Policies and procedures are organized, reviewed, and available to staff.	X					Solutions maintains written policies and procedures for all areas of the company. Policies indicate the policy effective date, review dates, the date of the most recent revision, and identification of approval activity. The Compliance Department maintains a master list of all policies and facilitates the annual review process. Each Business Unit's senior leadership is responsible for disseminating policies to staff and overseeing implementation of the policies.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities:						
1.1 Administrative oversight of day-to-day activities of the organization;	X					Solutions is a subsidiary organization of Community Health Solutions of America. Dr. Barbara Freeman, CMO, is responsible for the administrative oversight of day-to-day activities. The organizational chart indicates Dr. Freeman is listed as the Executive Director and Interim Medical Director. Dr. Freeman is serving in three different roles. Staff indicated they were actively recruiting a Medical Director and expect to have the position filled within the next month. Staff also reported the Executive Director position was being eliminated. *Recommendation: Continue the recruiting efforts to fill the Medical Director position. Also, determine if the vacant Executive Director position will be filled.*
1.2 Pre-assessment;	X					
1.3 Care coordination and enhanced case management;	X					Three full-time Directors of Care Coordination are responsible for the onsite Care Coordinators. A Care and DME Advocate Manager oversees the Care Advocates, DME Advocates, and Parent Advocate. Three vacant positions were noted on the organizational chart, and staff reported those positions had been filled.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Provider services and education	X					
1.5 Quality assurance;	X					Cindy Sterner is the Senior Quality Assurance Analyst.
1.6 Designated compliance officer.	X					Shane Crawford is the Compliance Officer responsible for carrying out the Compliance Plan.
2. The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, the following are included:						
2.1 Criminal background checks are conducted on all potential employees.	X					Policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing, provides the process for verification of staff qualifications and screenings. The policy discusses the verification of clinical licenses, CPR certification, TB Test results, and background checks. Policy HR 01.41, Background Check Policy and Procedure (Non-Clinical Positions), addresses the criminal background checks for non-clinical staff.
2.2 Verification of nursing licensure and license status.	X					
2.3 Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs.	X					All employees are screened upon hire to determine if they have been excluded from participation in any state or federal programs. Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks, indicates the Human

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Resources Department performs the initial exclusions review and the Compliance Department conducts monthly exclusion monitoring.
2.4 Ensuring Care Coordinators meet all contract requirements.	X					
2.5 Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a participant's Person-Centered Service Plan.	X					
3. Employee personnel files demonstrate compliance with contract and policy requirements.		X				CCME reviewed a sample of personnel files and found the initial exclusion screenings had been conducted. However, the files lacked evidence of the monthly exclusion monitoring as required by Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks. Solutions provided additional screenshots of monthly queries to demonstrate the exclusion screenings were conducted. For the review period (June 2021 through May 2022) none of the files contained 12 months of screenings. Other findings in the personnel files included a lack of PPD testing results for clinical staff, and evidence of HIPAA and Compliance training. Solutions indicated that due to COVID-19 and as clinical staff did not conduct face-to-face visits, the PPDs were not required. The roster of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						employees completing the required HIPAA and Compliance training was provided after completion of the onsite visit. *Quality Improvement Plan: Review processes needed to ensure that steps are taken to complete monthly exclusion monitoring to align with Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting.*
I. C. Governing Board/Advisory Board						
1. The Organization has established a governing body or Advisory Board.	X					As noted in the 2022 Strategic Quality Plan, the Corporate Board of Directors is ultimately responsible for the program. Members include the Chief Executive Officer, owners of CHS, and other appointed stakeholders. The Board meets on a quarterly basis.
2. The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined.	X					
I. D. Contract Requirements						
1. The organization carries out all activities and responsibilities required by the contract, including but not limited to:						
1.1 Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday.	X					Solutions' website and Provider Manual indicate the hours of operation are 8:00 a.m. to 5:00 p.m. Contact information is included.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Adherence to contract requirements for holidays and closed days.	X					
1.3 Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS.	X					Processes for supervisory visits and ride along audits with Care Coordinators are found in Policy CHS.CM.MCCW.05.01, Medically Complex Criteria-Onsite Supervisory Visits. Policy CHS.CM.MCCW.05.02, Chart Review Process, provides additional information about ride along audits and details the chart audit process. Ride along audits and routine chart audits alternate every quarter. Due to COVID-19, ride-along audits are not occurring as there are no face-to-face interactions with participants. Staff indicated all chart audit frequency has increased because of suspending the ride along audits.
1.4 Organization and participant record retention and availability as required by the contract.	X					Policy CHS.ISP.ALL.11.45, Record Retention Destruction, states records will be maintained for a period of 10 years from either the date of final payment under the Contract, or completion of the Contract, whichever is later.
1.5 Participant materials written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages.	X					
1.6 Processes are in place to ensure care coordination services are available statewide.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. E. Confidentiality *42 CFR § 438.224*						
1. The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy.	X					All staff including remote and onsite staff receive HIPAA and information security training prior to being allowed access to Protected Health Information. All employees receive training at least annually.
I. F. Data Systems/Security *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1 Policies, procedures and/or processes are in place for addressing data, system, and information security and access management.	X					Solutions has a thorough and well-organized collection of security policies and procedures. Specifically, the organization has sound policies and procedures governing the use of portable devices to store sensitive data. Additionally, policies and procedures limit the ways PHI can be used and requires staff and partners to adhere to the rule of least privilege.
2. The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented.	X					Solutions has a detailed business continuity plan to assist in avoiding service interruptions and minimize the impact of incidents that cause interruptions. Should a disaster occur, the organization has regular backups that are tested weekly and stored offsite.
I G. Compliance and Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following:						
1.1 Written policies, procedures, and standards of conduct comply with federal and state standards and regulations.	X					Policy CHS.COMP.ALL.01.03, Fraud & Abuse Prevention Training, outlines the process for the identification and prevention of fraud, waste, and abuse (FWA). The Compliance Plan details the FWA guidelines developed in alignment with the Code of Ethical Conduct and the applicable Fraud Prevention Plan. Solutions expects its directors, officers, employees, and affiliates to conduct business in accordance with all relevant laws to refrain from any illegal, dishonest, or unethical conduct. New member materials include information on methods for reporting suspected or actual fraud, waste, and abuse. These methods include telephonic or electronic options. The Employee Handbook states employees are required to report any event of Company fraud, impropriety, waste, and/or abuse that is suspected or witnessed to their manager or to the Compliance Officer. Reports may also be made through the CHS Fraud and Abuse Hotline. The Company will not take any adverse action or otherwise retaliate against any person due to the good faith reporting of a suspected violation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 A compliance committee that is accountable to senior management.	X					
1.3 Employee education and training that includes education on the False Claims Act, if applicable.	X					
1.4 Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers.	X					
1.5 Enforcement of standards through well-publicized disciplinary guidelines.	X					
1.6 Provisions for internal monitoring and auditing.	X					The Compliance Program document indicates that the Compliance Officer establishes and maintains relationships with the operational staff and management to conduct audits, review oversight and monitoring reports, review and update policies and procedures, educate on FWA and privacy, and provide summary status reporting to the Chief Executive Officer. Each audit includes findings, trends, process improvement/best practices recommendations, and corrective action planning. The Compliance Officer creates and executes an audit calendar on a quarterly basis and to identify areas to be audited based on risk, past findings, and new guidelines.
1.7 Provisions for prompt response to detected offenses and development of corrective action initiatives.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 A system for training and education for the Compliance Officer, senior management, and employees.	X					
1.9 Processes for immediate reporting of any suspicion or knowledge of fraud and abuse.	X					
2. The organization reports immediately any suspicion or knowledge of fraud or abuse.	X					Policy CHS.COMP.ALL.01.04, Fraud & Abuse, indicates that the Compliance Officer or designee, or a member of the Executive Committee, will report the findings of FWA investigations within 10 business days to appropriate clients, agencies, and integrity programs to comply with state, federal, and contract requirements.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
1. The organization formulates and acts within policies and procedures related to initial and ongoing education of providers.	X					New provider orientation is conducted by the Director of Medical Informatics and Credentialing within 30 days of contracting. A list of topics covered in provider orientation is included in Policy CHS.PM.MCCW.01.01, Provider Orientation/Training.
2. Initial provider education includes:						
2.1 Organization structure, operations, and goals.	X					The Provider Manual includes addresses and phone numbers for SC Solutions and the corporate headquarters. Also included are names, titles, and contact information for key personnel, a description of the MCCW's purpose and goals, Enhanced Primary Care Case Management (PCCM) processes, and detailed information about the role of the provider in caring for MCCW participants.
2.2 Medical record documentation requirements, handling, availability, retention, and confidentiality.	X					The Provider Manual informs that providers must maintain accurate, complete medical records and that participant medical records are subject to review. The records must be maintained in a secure location to ensure confidentiality and retained for a minimum of 13 years. Documentation elements that must be included in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the medical records are listed in the Provider Manual.
2.3 How to access language interpretation services.	X					Toll free telephone and TTY numbers to access free language services are listed in the Provider Manual. Information includes the free language services include qualified verbal and sign language interpreters, as well as alternate formats of written materials (large print, braille, audio, accessible electronic formats, etc.).
3. The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures.	X					Solutions staff reported during the onsite visit that no face-to-face ongoing provider education is currently being conducted. Staff reported that the Provider Manual was updated in late 2021, and providers were informed of the revisions. The current Provider Manual is posted on Solutions' website. *Recommendation—Consider alternate methods/forums for conducting ongoing provider education, such as through webinars, virtual meetings, etc.*

III. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IIV. QUALITY IMPROVEMENT						
III A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants.	X					Solutions' 2022 Strategic Quality Plan provides a description of the health plan's approach to quality management and performance improvement. The Strategic Quality Plan describes the program's goals, objectives, structure, and resources. Solutions' Chief Medical Officer is primarily responsible for oversight of the quality program, including clinical performance outcome monitoring. It was unclear if the Strategic Quality Plan had been approved. The note in the footer indicated the document was approved by the Compliance & Quality Management Committee (CQMC) on June 27, 2022. However, the CQMC did not meet on that date. Also, page three indicates the document contained appendices. During the onsite visit, staff explained the Strategic Quality Plan did not have appendices and had been sent to the CQMC via email for review and approval. *Recommendation: Correct the Strategic Quality Plan and remove the references to appendices. Also, update the CQMC minutes and add an addendum regarding the electronic review and approval of the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Strategic Quality Plan that occurred outside of the scheduled committee meeting.
2. An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity.	X					Solutions develops a Quality Work Plan annually. CCME requested and received the 2021 and 2022 Quality Work Plans. The Work Plans included the projects/activities, interventions, start dates, estimated completion dates, responsible parties, and quarterly updates. During the previous EQR, CCME recommended Solutions update the estimated completion dates. This recommendation was completed by Solutions, and the estimated completion date was included for each activity.
III B. Quality Improvement Committee						
1. The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Solutions' Corporate Board of Directors is ultimately responsible for the health plan's Quality Improvement Program. The Board is responsible for the initiation of the QI Program and direct its implementation throughout the organization. The CQMC is the local committee responsible for oversight of all aspects of the QI Program. The committee is chaired by the Chief Medical Officer. Voting members include the Chief Compliance Officer, Manager of Medical Informatics, the Quality Coordinator, and other team leads.
2. The QI Committee meets at regular intervals.	X					According to the Strategic Quality Plan, the CQMC meets no less than quarterly. The minutes received indicated for 2021, the committee met in the first and third quarters. Solutions indicated the meeting scheduled for second and fourth quarters had to be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						cancelled. For 2022, the committee is on track for meeting quarterly. The minutes of the meetings held in the first and second quarters of 2022 were provided.
3. Minutes are maintained that document proceedings of the QI Committee.	X					
III C. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Solutions evaluates the overall effectiveness of the QI Program and reports this assessment to the CQMC. The Quality and Performance Improvement 2021 Annual Report was provided. This evaluation included the results and/or updates of all activities conducted in 2021. The program evaluation also included the goals for 2022.
2. The annual report of the QI program is submitted to the QI Committee.	X					The program evaluation was sent to the CQMC and the Board of Directors for review and approval.

IV. CARE COORDINATION/CASE MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. Care Coordination/Case Management						
1. The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs.	X					Solution's Medically Complex Children Waiver Program Description provides an overview of the organization, program oversight, and program goals and objectives. Program policies provide details and processes to guide staff in conducting daily Care Coordination/Case Management activities.
2. Policies and procedures and/or the program description address the following:						
2.1 Structure of the program.	X					Solutions is contracted by SCDHHS to provide care coordination for participants of the Medically Complex Children Waiver (MCCW). The program structure is addressed in the Medically Complex Children Waiver Program Description.
2.2 Lines of responsibility and accountability.	X					Solutions is a subsidiary of Community Health Solutions of America (CHS). The CHS Board of Directors has ultimate oversight of Solutions. Solutions' Executive Director / Chief Medical Officer (CMO) oversees program operations and is responsible for ensuring the goals and objectives of SCDHHS and Solutions are aligned. The CMO reports to the Board. The Solutions Medical Director provides clinical oversight and decision making and works closely with

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Directors of Care Coordination, who oversee the daily activities of Care Coordinator staff.
2.3 Goals and objectives of Care Coordination/Case Management.	X					
2.4 Intake and assessment processes for Care Coordination/Case Management.	X					Intake and assessment processes are described in Policy and Procedure CHS.CM.MCCW.01.01, Intake/Admissions Policy and in related policies, including Policy and Procedure CHS.CM.MCCW.01.02, MCCW-Medical Eligibility Assessment and Policy and Procedure CHS.CM.MCCW.01.19, Level of Care Assessment.
2.5 Providing required information to participants at the time of enrollment.	X					Materials provided to participants at the time of enrollment include: ○Admission Agreement and Freedom of Choice forms ○Authorization to Disclose Health Information and the Authorization for Release of Information / Appointment of Authorized Representative forms ○Person Centered Service Plan ○Information about rights and responsibilities, non-compliance, various waivers, reporting fraud, waste, and abuse, selecting a home care provider, appeals, community resources, and Child Protective Services ○Information about programs including Family Connection, BabyNet, Assistive Technology, and Non-emergency Medical Transportation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable.	X					Policy and Procedure CHS.CM.MCCW.02.01, Care Coordination Process, details the schedule for monthly, quarter, semi-annual, and annual contacts with participants. Due to the public health emergency from COVID-19, all interactions with participants and families/caretakes are conducted by telephone.
2.7 Processes to develop, implement, coordinate, and monitor individual Person-Centered Service Plans with the participant/caregivers and the PCP.	X					Processes to develop, implement, coordinate, and monitor individual PCSPs with participants/caregivers and the primary care provider are found in Policy and Procedure CHS.CM.MCCW.01.18, Person Centered Service Plan, and Policy and Procedure CHS.CM.MCCW.01.08, Care Planning/Monthly Summary Report. PCSPs are created at the time of enrollment and updated a minimum of twice yearly, during semiannual and annual contacts/visits, and as needed. The PCSP identifies problems, goals, and corresponding interventions. Every month, a Monthly Summary Report (MSR), which is a detailed summary of the PCSP, is reviewed with the responsible party and updated as needed. The MSR is also reviewed by the primary care physician at pre-defined intervals.
2.8 Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plan.	X					At the time of creation and with each revision or update, the participant or responsible party signs the PSCP to confirm they were involved in the development of the PCSP, and it reflects the participant's priorities, goals, desires, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						preferences. A copy of the PSCP is given to the participant/responsible party.
2.9 Process to regularly update and evaluate the Person Centered Service Plans on an ongoing basis.	X					PCSPs are updated during each semiannual and annual visit and as needed. Each month, Care Coordinators review the Monthly Summary Report with the participant/responsible party and makes any needed changes or updates.
2.10 Processes for following up with participants admitted to the hospital and actively participate in discharge planning.			X			Policy and Procedure CHS.CM.MCCW.03.01, Discharge Planning/Disenrollment, only addresses discharge from Solutions and from the MCCW program. A policy addressing discharge planning for participants who are admitted to a hospital was not found. Solutions staff confirmed a policy has not been created for this topic, but stated Care Coordination staff are encouraged to access the electronic health record systems to which they have access (Prisma and MUSC) for discharge summaries, etc. Staff also stated Care Coordination staff work hospital care management staff to ensure discharge needs are met. *Quality Improvement Plan: Develop and implement a policy and procedure that details the roles and responsibilities of Care Coordination staff in discharge planning processes for currently enrolled participants who are admitted to a hospital.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Processes for reporting suspected abuse, neglect, or exploitation of a participant.		X				Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, states Care Coordinators review Child Protective Services information with the responsible party during the Pre-Admission Screening visit. Responsible parties are informed that Care Coordinators and other staff are required to report any signs of/suspected abuse or neglect to the Department of Social Services. This policy details how staff enter information into the Phoenix system but does not provide detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant or actions taken after filing a report. *Quality Improvement Plan: Revise Policy and Procedure CHS.CM.MCCW.01.12, Child Protective Services, to include detailed information about the process for reporting suspected abuse, neglect, or exploitation of a participant, and any actions taken/follow-up after a report is made.*
2.12 A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided.	X					As stated in Policy and Procedure CHS.CM.MCCW.04.02, Back Up Service Provision, if a Care Coordinator is unavailable to provide care for a participant, the Directors of Care Coordination will assign an alternate staff person to provide the services to the participant. The participant's responsible party is notified of the situation. If Solutions is unable to provide services to the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						participant, SCDHHS is notified within five business days.
3. The organization provides a written, formal evaluation of the Person Centered Plan to SCDHHS every 6 months or upon request.	X					
4. The organization conducts Care Coordination and Case Management functions as required by the contract.	X					A sample of Care Coordination care files was reviewed. Issues identified included: ○Two files had undated Growth and Development Assessment forms. *Recommendation: Ensure all Growth and Development Assessment forms are signed and dated at the time of completion.*