Constellation Quality Health

Select Health of South Carolina

2024 External Quality Review

Submitted: September 19, 2024

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 requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate the MCOs' 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 2024 External Quality Review (EQR) that Constellation Quality Health (Constellation) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Select Health of South Carolina (Select Health) since the 2023 Annual Review.

The goals and objectives of the review were to:

- Determine if the health plan is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations
- Evaluate the status of deficiencies identified during the 2023 Annual EQR and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate contracted health care services are being delivered and of good quality

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

Summary and Overall Findings

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

- Disenrollment Requirements and Limitations (*§ 438.56*)
- Enrollee Rights Requirements *(§ 438.100*)
- Emergency and Post-Stabilization Services *(§ 438.114)*
- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*

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

To assess Select Health's compliance with the 14 *Subpart D* and QAPI standards as related to quality, timeliness, and access to care, Constellation's review was divided into seven areas. Those areas included:

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

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

Administration

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

Select Health develops policies and procedures to ensure compliance with regulations, standards, and contractual requirements. Policies and procedures are reviewed annually, and staff are educated about new and revised policies and procedures.

All required key positions are filled and overall staffing is appropriate for conducting the required health plan activities.

The 2023 Select Health of South Carolina Compliance Program and the 2023 Program Integrity Plan for Select Health of South Carolina outline processes for ensuring compliance with federal and state regulations and for monitoring, detecting, preventing, and investigating fraud, waste, and abuse (FWA). Related policies and procedures provide detailed information about compliance and FWA topics. Select Health's Compliance Committee provides comprehensive monitoring of the Compliance Program, makes recommendations for the Annual Compliance and Privacy Work Plan, and provides guidance for all compliance activities. No issues were noted with the committee's

meeting frequency or quorum requirements. The health plan conducts routine monitoring and auditing activities to evaluate the effectiveness of the Compliance and FWA Programs and to identify and respond to areas of risk.

Compliance training is mandatory for employees upon employment and then annually. Training is also given to the members of the Board of Directors and subcontractors. The training addresses federal and state laws and mandates, the Code of Conduct, and conflicts of interest. Additional focused training is provided for specific high-risk areas within the organization. Select Health notifies employees of various methods for reporting compliance and/or FWA concerns, enforces a no-retaliation policy for good-faith reporting, and allows anonymous reporting.

Policy MED (PA) 150.402, Beneficiary Lock-In Program, describes processes and requirements for the Pharmacy Lock-In Program. However, it does not specify the timeframe for finalizing the member's pharmacy lock-in once the referral is received from SCDHHS or the timeframe for notifying members by letter of their removal from the program.

Provider Services

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

Credentialing and recredentialing processes are documented in policies. However, organizational provider rights related to credentialing and the requirement for providers to be enrolled with SCDHHS as a SC Medicaid provider are not addressed in the applicable policy. Discrepancies were identified in the timeframe for notifying SCDHHS of a credentialing denial for program integrity-related reasons. Processes for ongoing provider monitoring for quality of care and service, for suspending or terminating practitioners for serious quality of care or service issues, and for sanctions and exclusions are addressed in additional policies. No issues were found in the samples of initial credentialing and recredentialing files for practitioners. For organizational providers, one file for a dialysis center did not include evidence of the required CMS certification.

Select Health's Credentialing Committee conducts peer reviews to make credentialing determinations. Voting members of the committee include an array of practitioner specialties. The Chief Medical Officer chairs the committee, with meetings held monthly. The established quorum requirement is the presence of 51% of the voting membership.

Appropriate processes are in place for initial and ongoing provider education, which is conducted by Account Executives via in-person or virtual sessions, letters/mailings, Provider Manual updates, information relayed through Provider Relations, newsletters, etc. The Provider Manual and Select Health's website are resources for information needed for providers to function within Select Health's network.

Select Health adopts and implements Clinical Practice Guidelines and Preventive Health Guidelines. Providers are educated about the guidelines and can access them on the website and in hard copy upon request.

Select Health educates providers about requirements for medical record documentation, maintenance, storage, and confidentiality, and assesses provider compliance with these requirements through an annual medical record audit. Results of the medical record audits are used to determine the need for additional provider education, to share best practices, etc. An annual summary of performance is reported to the Quality of Clinical Care Committee for review and recommendations. Through the medical record audits, Select Health also tracks continuity and coordination of care and presents an annual report to the Quality Assessment and Performance Improvement Committee (QAPIC) as part of Quality Improvement (QI) Program Evaluation. The QAPIC initiates action to address identified continuity and coordination of care issues.

Constellation conducted a validation review of Select Health's provider network following the CMS protocol titled *EQR Protocol 4: Validation of Network Adequacy*. Select Health's provider network was found to be adequate and consistent with the requirements of the CMS protocol.

Inconsistencies were noted in the geographic access standard for primary care physicians (PCPs) and specialists when comparing a policy to the Annual Assessment of Network Adequacy and Network Development Report. Onsite discussion and review of Geo Access reports confirmed Select Health is using appropriate standards for geographic access and that the health plan contracts with all required Status 1 and Status 2 provider types. Select Health follows an established process to address any identified network adequacy opportunities through a provider outreach strategy. Select Health monitors provider compliance with appointment access standards and takes action to address any identified issues. Results are reported annually to the Quality of Service Committee (QSC) and QAPIC.

Select Health monitors its network's ability to serve members with special needs and cultural requirements by collecting and evaluating provider race, ethnicity, and language data and abilities to accommodate members with mental and/or physical disabilities. Information about cultural competency is included on the website and in the Provider Manual.

Select Health maintains a printed (PDF) Provider Directory and the website offers an online directory that includes the ability to search for providers. The review found that neither of Select Health's Provider Directories includes dispensing pharmacies, as required by the *SCDHHS Contract, Section 3.12.3.3*. Policy NM 159.308, Assessment of Physician Directory Accuracy, describes processes for validating information in provider directories through an annual online

Provider Directory audit. Results are reported to the QSC. This report was last presented to the QSC in the Spring of 2024.

For the Telephone Provider Access Study conducted by Constellation, the successful answer rate was 47%. This is a nonsignificant decrease in successful calls from the previous year's rate of 55%. This resulted in a score of "Not Met" for the related standard within the Provider Services section of the review.

Member Services

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

Member rights and responsibilities are included in Select Health's policies, the Member Handbook, website, and in the Quick Start Guide. The Welcome Kit is provided to new members within 14 calendar days from the date of receipt of the eligibility file and includes the Quick Start Guide. Members are provided with information to address a variety of needs in the Member Handbook, member materials, and on the website.

The Member Handbook describes core benefits, covered services, prior approval requirements, and limitations. Members are notified of changes to benefits via the Healthy Now member newsletter. However, when changes were made effective February 2024, notification was not sent until the summer edition of the member newsletter. Constellation recommended that Select Health review processes to ensure timely notification to members about changes to benefits.

The Member Handbook and policies provide information about selecting a PCP, accessing 24-hour care, emergency assistance, and steps to disenroll from the health plan. Members are provided with resources to address chronic health conditions and disease management.

Select Health contracts with a vendor, Press Ganey, to conduct both the child and adult member satisfaction surveys. For the current measure year, the adult response rate was 12.5%, which is a decline from the previous year's rate. For year over year trending, the findings showed improvements in Rating of the Health Plan, Getting Needed Care, Customer Services, Rating of Health Care, Doctor Communication, Coordination of Care, and Rating of Specialists. The largest declines were in Discussion of Cessation Strategies and Rating of Personal Doctors. It was recommended that Select Health review the Agency for Healthcare Research and Quality (AHRQ) webcast from January 2024 regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS) response rates, which offers ideas such as promotional material, prenotification letters, and a longer survey collection period.

The child response rate was 13.1%, which is a decline from last year's rate. Improvements occurred in the areas of Getting Needed Care, Rating of Health Care, Getting Care Quickly, and Doctor Communication. The largest decline was in Rating of Specialists. The Children with Chronic

Conditions (CCC) response rate was 15.2% which is a decline from the previous year's rate. For the CCC population, Rating of Health Plan, Getting Needed Care, Rating of Health Care, Getting Care Quickly, Doctor Communication, and Coordination of Care improved. The largest decline was in Rating of Specialists.

Policies describe processes for filing, acknowledging, and resolving verbal and written grievances. The definition of a grievance, grievance filing options, and associated timeframes are consistent in policy, the Member Handbook, Provider Manual, and Select Health's website. Grievances are appropriately categorized and monitored for trends, which are reported quarterly to the Quality of Service Committee as reflected in meeting minutes. A sample of grievance files was selected and reviewed for this EQR. All were acknowledged, investigated, and resolved timely with appropriately documented member correspondence.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Select Health's QI Program is described in the Quality Management Program Description for 2024 by Select Health of South Carolina. The Program Description provides a comprehensive outline of the program's structure and lines of responsibility. It details the roles and responsibilities of various committees, departments, and key positions involved in overseeing quality improvement activities, monitoring performance, conducting audits, and ensuring compliance with standards. The document also specifies the delegation of health plan functions to subcontractors, the reporting relationships, and the involvement of different stakeholders in ensuring the quality of care and services provided to members.

Information regarding the QI Program was found on Select Health's website. However, this information was outdated. The QI goals shared with providers were the 2023 program goals and the goals shared with members were the 2022 program goals.

The Quality Assessment and Performance Improvement Committee within Select Health is a vital entity responsible for overseeing the QI Program. This committee plays a key role in developing, implementing, monitoring, and evaluating the program. The committee structure and responsibilities are outlined in the committee charter. The Quality Clinical Care Committee and the Quality of Service Committee are subcommittees of the QAPIC. Both subcommittees provide direction and oversight of their respective areas of clinical and service QI activities.

Select Health provides direct feedback to PCPs on their performance via a provider report card. The report card offers direct feedback on key quality measures compared to a peer group within the Select Health network. The report cards track progress and help identify areas for improvement. PCPs can access reports on their assigned members through the secure Provider Portal (NaviNet). Policy QI 154.006, EPSDT/Prevention Screening Outreach, and Policy QI 154.014,

Monitoring Foster Care Membership Utilization and Compliance with Well Care Visits, describe how Select Health tracks member and provider compliance with EPSDT services. This includes notification of members and providers about age-appropriate and relevant preventive health screenings and services, as well as tracking when members did not receive recommended assessments and/or treatments. Member and Provider Incentives Programs are offered by Select Health to encourage and reward members and providers for engaging in specific health-related activities and behaviors.

Select Health conducts an annual evaluation of the QI Program which involves various aspects such as clinical performance, quality studies, and activities. The Quality Management Program Evaluation of Calendar Year 2022 was submitted. Select Health indicated they were in the process of completing the 2023 QI Program Evaluation. The health plan anticipated this evaluation would be completed and submitted to the QAPIC for review and approval on August 24, 2024.

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

All relevant HEDIS performance measures for the current measure year 2023 (MY2023), the previous measure year 2022 (MY2022), and the change from 2022 to 2023 are reported in the QI section of this report. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial rate increases or decreases from 2022 to 2023. Rate changes shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%). Substantial changes in year-over-year trending were found in two measures.

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2022	Measure Year 2023	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
**Poor HbA1c Control*	50.85%	40.39%	-10.5%
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	66.67%	55.88%	-10.8%

**A lower rate for this measure indicates improvement.*

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

Select Health submitted two PIPs for validation. The topics were Diabetes Outcomes Measures and Well Care Visits for the Foster Care Population. The validation found the two PIPs met all the requirements and received scores within the "High Confidence in Reported Results Range." A summary of each PIP's status and the interventions is included in the following tables.

Table 2: Diabetes Outcomes Measures PIP

Diabetes Outcomes Measures	
The aim for the diabetes PIP is to lower HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and whose HbA1c levels are not <8%). The diabetes outcomes rates for measure year 2024 were not in the report, but a quarterly report as of April 2024 was submitted. The HEDIS audit reports showed improvement for HbA1c Control (<8%) from 42.09% in MY2022 to 50.12% in MY2023. Controlling High Blood Pressure at <140/90 mm/hg improved from 61.31% in MY2022 to 61.56% in MY2023.	
Previous Validation Score	Current Validation Score
84/85=99% High Confidence in Reported Results	100/100=100% High Confidence in Reported Results
Interventions	
• Data sharing by direct electronic medical record access • Year-round medical record review • Value based payment programs • Member incentives • Provider education • Newsletters	

Table 3: Well Care Visits for the Foster Care Population

Well Care Visits for the Foster Care Population
The aim for the Well Care Visits for Children and Adolescents in Foster Care PIP is to increase compliance with well care visits for children and adolescents in foster care. For this PIP, there are several rates monitored. Several of these rates have been retired, thus the plan is tracking the current HEDIS measures only, including the Well-Child Visits in the First 30 Months of Life (W30) and the Child and Adolescent Well Care Visits (WCV). The W30 for first 15 months showed a 2023 rate of 53.96%, a slight decline from 54.93% in 2022. The W30 for 15-30 months showed 84.0%, a decline from the 2022 rate of 87.01%. The WCV rate for 3–11-year-olds was 76.82%, which is a slight improvement over the 2022 rate of 76.30%. For 12–17-year-olds, the WCV rate was 71.61%, a decline

Well Care Visits for the Foster Care Population	
from the 2022 rate of 72.22%.For 18–21-year-olds, the WCV rate was 43.25%, a slight decline from the 2022 rate of 43.54%. The total WCV rate was 71.31%, down from 71.47% in 2022.	
Previous Validation Score	Current Validation Score
84/85=99% High Confidence in Reported Results	74/75 = 99% High Confidence in Reported Results
Interventions	
• Data sharing • Care management calls to new members • Monthly gaps in care reports • Clinical rounds • Weekly appointment reports • Provider education • A texting campaign • The Take Flight Program • Member incentives	

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)

Select Health's Utilization Management (UM) Program Description and various policies outline the health plan's UM Program. PerformRx's Program Description provides a descriptive overview of the health plan's pharmacy program. Select Health's Medical Director provides overall oversight of the UM Program. The Behavioral Health Director and Pharmacy Director provide clinical oversight of their respective programs.

Initial review of a request for services is conducted by Select Health's licensed clinical staff using evidence-based clinical criteria. For quality assurance, Select Health conducts Inter-Rater-Reliability testing and Clinical Audits of the review decisions made by their physician and non-physician review staff. Standard requests for authorization are processed within 14 calendar days, urgent requests are processed within 72 hours, and pharmacy requests are processed within 24 hours. Constellation's review of a sample of approval and denial files reflected that the clinical determinations were made according to contractual requirements.

Processes for handling standard and expedited written and verbal appeal requests are described in Policy MMS.100, Member Grievances and Appeals Process, the Utilization Management Program Description, the Member Handbook, the Provider Manual, and Select Health's website. All appeal files reviewed for this EQR were resolved in a timely manner and were reviewed by appropriately credentialed reviewers. However, none of the appeal resolution notifications included evidence that the notice had been sent to the member via certified mail as required by the *SCDHHS*

Contract, Section 9.1.6.3.1.1. and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 9.* This was discussed during the onsite and Select Health indicated the notices are not sent via certified mail despite the policy, the Provider Manual, and the Member Handbook indicating the notices are sent via certified mail.

The scope, objectives, and guidelines for the health plan's care management program, foster care management program, and transition of care services are outlined in the Population Health Management Program Description and in several policies. Members are referred to care management services through various resources. Once an initial assessment has been completed, members are stratified to an appropriate risk level and are provided services based upon their identified needs.

Select Health also offers Targeted Care Management (TCM) services for members with specialized needs. During an onsite discussion, Select Health described that TCM services are also offered for adults in need of protective services. However, these services were not included in the program descriptions or in policy.

The review of the sample care management files indicated that care management activities were provided as required by contract.

Delegation

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

For this EQR, Select Health has delegation agreements with 16 entities. Each delegation agreement specifies the activities the delegate will perform on behalf of the health plan. The agreements include provisions for oversight monitoring.

Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, outlines Select Health's policy and procedure for delegation of credentialing and recredentialing activities. Policy 277.010, Oversight of Subcontractor-Delegates, outlines the policy and procedures for oversight of non-credentialing delegates. Both policies cover responsibilities, contract implementation procedures, monitoring processes, and corrective action plans.

Select Health provided documentation of the annual oversight audits conducted for all non-credentialing and credentialing delegates. Results of the credentialing delegate audits are presented to the Credentialing Committee, and the non-credentialing monitoring results are presented to the Quality of Service Committee. There were no issues identified with the monitoring.

Mental Health Parity

Constellation is required to conduct a Mental Health Parity assessment to determine if Select Health met the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment is conducted as a two-step process. Step one involves assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits.

NQTLs are assessed for both comparability of standards/processes, and the stringency with which they are applied. Constellation reviewed Select Health's supporting documentation to assess both elements of NQTL Parity: comparability and stringency. Compliance with these two factors depends on a parity of process, policy, and practice. The NQTL assessment found the mental health services comply with parity requirements of comparability and stringency.

Two templates were provided to Select Health to complete for the Mental Health Parity Assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There are two steps required to conduct this review. For step one, Constellation determined if a particular type of financial requirement or QTL applied to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, Constellation determined the predominant value for financial or treatment limitations by identifying the value that applied to more than half of medical/surgical benefits within that classification.

Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. Technical assistance is provided until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which Select Health implemented the actions to address deficiencies identified during the previous EQR and found there was no improvement in the percentage of successfully answered calls for the provider access call study conducted by Constellation. Therefore, this was an uncorrected deficiency from the previous EQR.

Details regarding the 2023 QIP can be found in *Attachment 4: Assessment of Quality Improvement Plans from Previous EQR*.

Conclusions

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

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

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. C 2	1	1	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	2	2	100%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	12	10	83%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	38	97%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	19	95%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	3	3	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D	9	9	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%

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

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

- For Availability of Services and Assurances of Adequate Capacity and Services, it was found that the online and printed Provider Directories do not include dispensing pharmacies. Also, there was no improvement in the percentage of successfully answered calls for the provider access call study conducted by Constellation.
- For Provider Selection, it was found that policies did not address organizational provider rights related to credentialing and did not address the requirement for providers to be enrolled with SCDHHS as a SC Medicaid provider. Additionally, inconsistencies were found in the timeframe for notifying SCDHHS of a credentialing denial due to program integrity-related reasons.
- For the Grievance and Appeal Systems, the appeal resolution notifications were not sent to the member via certified mail with return receipt requested, as required by the *SCDHHS Contract, Section 9.1.6.3.1.1.*

Table 5: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2023 review. For 2024, 213 out of 218 standards received a score of "Met." Three standards received a score of "Partially Met," and two standards received a score of "Not Met."

Table 5: Scoring Overview

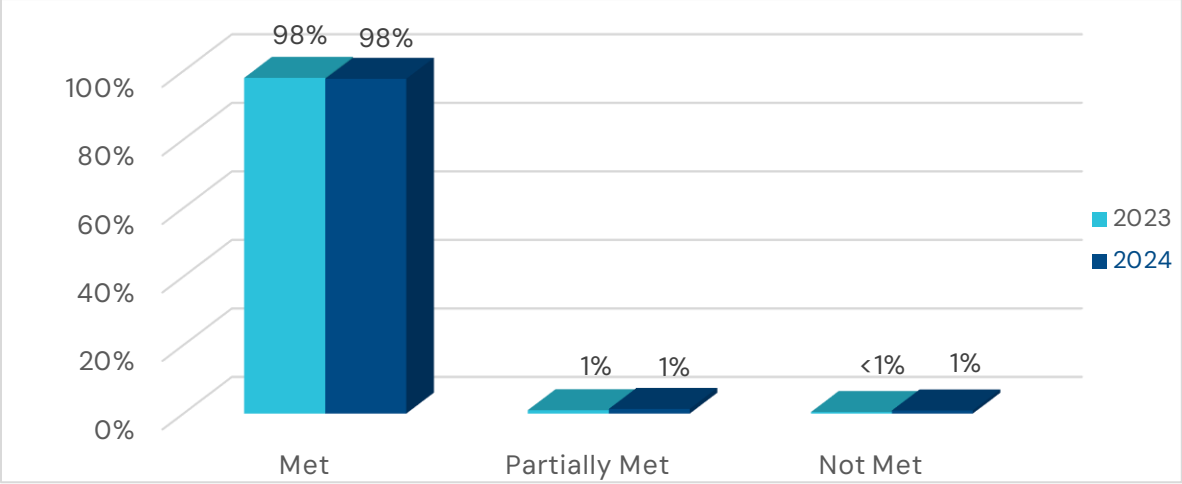
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	40	0	0	0	0	40	100%
2024	39	1	0	0	0	40	98%
Provider Services							
2023	79	0	1	0	0	80	99%
2024	75	2	1	0	0	78	96%
Member Services							
2023	33	0	0	0	0	33	100%
2024	33	0	0	0	0	33	100%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Quality Improvement							
2023	16	0	0	0	0	16	100%
2024	16	0	0	0	0	16	100%
Utilization							
2023	43	3	0	0	0	46	93%
2024	45	0	1	0	0	46	98%
Delegation							
2023	2	0	0	0	0	2	100%
2024	3	0	0	0	0	3	100%
Mental Health Parity							
2023	2	0	0	0	0	2	100%
2024	2	0	0	0	0	2	100%
Totals							
2023	215	3	1	0	0	219	98.17%
2024	213	3	2	0	0	218	97.71%

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

The 2024 Annual EQR shows that Select Health achieved "Met" scores for 98% of the standards reviewed. The following figure provides a comparison of the current review results to the 2023 review results. The areas of review which did not meet or partially met all the standards included the policy for the Pharmacy Lock-In Program, documentation of organizational provider credentialing rights, the timeframe for notifying SCDHHS of program integrity-related credentialing denials, information included in Provider Directories, the telephonic access study conducted by Constellation, and appeal resolution notifications not being sent by Certified Mail.

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 improvement. Specific details of strengths, weaknesses, and recommendations can be found in the sections that follow.

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

Strengths	Quality	Timeliness	Access to Care
Administration			
Processes for policy development and ongoing management are appropriate and staff are educated about new/revised policies by departmental leadership.	✓	✓	
All key positions are filled, and overall staffing is appropriate to conduct required health plan activities.	✓		
For information systems, documentation is reviewed on a regular basis and updated as needed. Disaster recovery testing is performed regularly with the most recent test successfully meeting the MCO objectives.	✓		
The Compliance Program and related policies provide detailed information about processes for ensuring compliance with laws and regulations.	✓		
The Code of Conduct is a thorough resource that provides employees with guidance about appropriate business behavior and conduct.	✓		
The Program Integrity Plan and related policies and procedures thoroughly document processes to prevent, monitor for, detect, investigate, and respond to FWA.	✓		
Provider Services			
The Credentialing Committee uses a peer review process to make credentialing determinations. Committee member specialties include Family Practice, Internal	✓		✓

Strengths	Quality	Timeliness	Access to Care
Medicine, Pediatrics, Obstetrics and Gynecology, Behavioral Health, and a Surgeon who attends on an ad hoc basis.			
No issues were found in the initial credentialing and recredentialing files for practitioners.	✓		
Select Health conducts appropriate activities to monitor providers for quality of care and quality of services issues and takes action to address any identified issues.	✓		✓
Ongoing monitoring is conducted to determine if network providers have any sanctions or exclusions that would prohibit their participation in the network.	✓		✓
Select Health uses appropriate geographic access standards for network providers, and contracts with all required Status 1 and Status 2 provider types.			✓
Providers are educated about cultural competency and Select Health evaluates its network's ability to meet the cultural, diversity, and other special needs of members.	✓		✓
The health plan evaluates provider compliance with appointment access standards and takes action to address any identified issues.	✓		✓
Initial and ongoing provider education is comprehensive.	✓		✓
Appropriate processes are in place for adoption and ongoing review of preventive health and clinical practice guidelines. Providers can access the guidelines on Select Health's website and can get hard copies upon request.	✓		✓
Providers are educated about medical record documentation standards and assessed annually for compliance.	✓		
Member Services			
Members are informed of their rights and responsibilities in a variety of helpful ways, such as the Member Handbook, Provider Manual, website, and member newsletters.	✓		
The Healthy Now member newsletter provides helpful information to members about programs and available resources.			✓
All grievance files reviewed for this EQR were addressed timely, with investigation steps documented clearly, and all letters to members contained contractually required information.	✓	✓	
Quality Improvement			
Select Health's QI Program Description includes the health plan's approach to health equity, data collection, monitoring, and quality improvement initiatives.	✓		
Provider performance monitoring and evaluation is included through mechanisms like PCP report cards, member-level data dashboards, and staff outreach.	✓		
The health plan was found to be compliant with the HEDIS technical specifications for rate calculations.	✓		
The performance improvement projects received a score in the High Confidence Range and met all the validation requirements.	✓		
Utilization Management			
Select Health maintained 100% target goal of timeliness for processing Psychiatric Residential Treatment Facility (PRTF) authorizations.		✓	
Select Health has a tracking system to report any provider appointments scheduled for children currently in foster care receiving care management services. This allows the South Carolina Department of Social Services nurses to update members' records and ensure there are no gaps in care, including immunization visits.	✓		✓

Strengths	Quality	Timeliness	Access to Care
First Choice Fit: Taking Flight is designed for members aging out of the foster care system, which aims to teach life skills.	✓		
All appeals files reviewed for this EQR period were resolved timely and were appropriately reviewed by the credentialed reviewer.		✓	✓
Delegation			
A Delegation Agreement is mutually agreed upon and executed, outlining the delegated functions, audit processes, and corrective actions if needed, providing a clear framework for the delegation process.	✓		
Select Health has a uniform process for contracting with, managing the performance of, and terminating subcontractors to whom activities have been delegated.	✓		
Oversight and monitoring the Delegate's compliance with requirements is conducted at regular intervals.	✓	✓	
Mental Health Parity			
Mental Health Parity Assessment showed mental health services are aligned with medical/surgical financial and treatment limitations.			✓

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

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Administration				
Policy MED (PA) 150.402, Beneficiary Lock-In Program, does not specify: • The timeframe for finalizing the restriction to one pharmacy from the date the referral is received from SCDHHS. • The timeframe for notifying members by letter of their removal from the program.	*Quality Improvement Plan: Revise Policy MED (PA) 150.402, Beneficiary Lock-In Program, to include the timeframe for finalizing the restriction of a member to one pharmacy once identified by SCDHHS and the timeframe for notifying members by letter of their removal from the program. Refer to the SCDHHS Contract, Section 11.10.2.2 and Section 11.10.5.*		✓	✓
Provider Services				

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, does not address: • Organizational providers' rights to review information submitted to support the credentialing application, to correct erroneous information, to receive the status of the credentialing or recredentialing application, to a non-discriminatory review, and to receive notification of these rights. • Requirements for providers to be enrolled with SCDHHS as a SC Medicaid provider.	*Quality Improvement Plan: Revise Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, to include providers' rights specified in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7 and to address the requirement for providers to be enrolled with SCDHHS as a SC Medicaid provider, as required by the SCDHHS Contract, Section 2.7.1.1.*	✓		✓
When discussing the timeframe for notifying SCDHHS of a credentialing denial due to program integrity-related reasons, Select Health staff reported that this information is included in a monthly report submitted to the State. However, Policy CR.100.SC indicates SCDHHS is notified within 15 calendar days when credentialing is denied for program integrity-related reasons, and Policy CR.103.SC indicates SCDHHS is notified within one business day of discovery of any for-cause program integrity-related denials or program integrity-related termination of credentialing.	*Quality Improvement Plan: Determine the timeframe within which Select Health will notify SCDHHS of program integrity-related credentialing denials and update Policies CR.100.SC and CR.103.SC to reflect that timeframe.*		✓	
For one initial credentialing file for a dialysis center, verification of the required CMS certification was not evident. Documentation included in the file indicates certification cannot be given until deficiencies are corrected.	*Recommendation: Ensure CMS certification is confirmed for provider types for which this is a requirement. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7.2.4 through Section 2.7.2.5.3.*	✓		✓
The review revealed an inconsistency in the geographic access standard for PCPs: • Policy NM 159.206, Availability of Practitioners, states the geographic access standard for PCPs is ≥95% of members with access to one provider within 30 miles.	*Recommendation: Update Policy NM 159.206, Availability of Practitioners, to reflect that Select Health is using a PCP access standard of ≥95% of members with access to two practitioners within 30 miles.*			✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
• The Annual Assessment of Network Adequacy and Network Development Report states the standard as ≥95% of members with access to two practitioners within 30 miles.				
An inconsistency in the geographic access standard for specialists was also noted: • Policy NM 159.206, Availability of Practitioners, states the geographic access standard for specialists is ≥95% of members with access to one provider within 50 miles. • The Annual Assessment of Network Adequacy and Network Development Report states the geographic access standard for specialists is ≥95% of members with access to two practitioners within 50 miles.	*Recommendation: Update Policy NM 159.206, Availability of Practitioners, to reflect that the access standard for specialists is ≥95% of members with access to two practitioners within 50 miles.*			✓
The *SCDHHS Contract, Section 3.12.3.3*, requires Provider Directories to "Include, at a minimum, information about the following Providers: (1) Primary Care Providers (PCPs), (2) Specialty and Behavioral Health Providers, (3) Pharmacies, (4) Hospitals, (5) Certified Nurse Midwives, (6) Licensed Midwives, (7) Long Term Support Service (LTSS) Providers and (7) Ancillary Providers." Review of Select Health's online and printed Provider Directories revealed neither includes dispensing pharmacies.	*Quality Improvement Plan: Include dispensing pharmacies in the printed and online Provider Directories, as required by the SCDHHS Contract, Section 3.12.3.3.*			✓
For the Provider Access Study conducted by Constellation, the successful contact rate declined from the previous year's rate.	*Quality Improvement Plan: Provide documentation on outreach to providers and the procedures that are in place to update provider contact information and panel status for providers.*			✓
Member Services				
There were noted declines in both adult and child member satisfaction survey response rates reported from the previous year.	*Recommendation: Review the AHRQ webcast from January 2024 regarding CAHPS response rates, which offers ideas such as promotional*	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
	material, prenotification letters, and a longer survey collection period.			
Quality Management				
Information regarding the QI Program was found on Select Health's website. However, the QI goals were outdated. The goals shared with providers were the 2023 goals and the goals shared with members were the 2022 goals.	*Recommendation: Update the goals for the Quality Management Program on the website.*	✓		
The Well Care Visits for the Foster Care Population showed declines in the indicator rates.	*Recommendation: Determine if additional barriers that have not been recognized are creating issues with the well care visits. Consider offering additional mobile, telehealth, or transportation services to meet the needs of the members.*	✓		
Utilization Management				
Select Health recently updated their policy referencing the Preferred Provider Program to corporate Policy UM.003, Standard and Expedited Prior Authorizations. During onsite discussion, the health plan mentioned that the UM Department and the Provider Network Management Director are in the final stages of developing the Preferred Provider Program. They indicated that there are currently two providers who might be eligible for participation.	*Recommendation: Complete finalization of a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy UM.03, Standard and Expedited Prior Authorization.*	✓		
There is currently no verbiage within Select Health's policy and Program Descriptions that outlines the specialty pharmacy process.	*Recommendation: Ensure that the Specialty Pharmacy process is clearly outlined within the policy or Program Description in accordance with the SCDHHS Contract, Section 4.2.21.*	✓		
Targeted Care Management services for adults in need of protective services were not included in the program description or in a policy.	*Recommendation: Include verbiage in a policy or Program Description to explicitly state that Targeted Case Management services are available for adults in need of protective services, in accordance with the SCDHHS Contract, Section 4.2.26.*	✓		✓
Policy MMS.100, Member Grievances and Appeals Process, and the UM Program Description do not describe processes ensuring that appeal resolution notices are sent to members via certified mail. The Member Handbook (page 28) and Provider Manual (pages 14, 42, and 43)	*Recommendation: Revise the process section of Policy MMS.100, Member Grievances and Appeals Process and include the requirement and the process for sending the appeal resolution notifications to the member via certified mail with return receipt requested as required by the SCDHHS Contract, Section 9.1.6.3.1.1 and the SCDHHS Policy and Procedure*	✓		✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
indicate that appeal resolution notices are sent to members via certified mail with return receipt requested.	*Guide for Managed Care Organizations, Section 9.*			
For the sample of appeal files reviewed for the 2024 EQR, none of the files included evidence that the appeal resolution notice had been mailed certified with return receipt requested, as required by the *SCDHHS Contract, Section 9.1.6.3.1.1.*	*Quality Improvement Plan: To comply with contractual requirements, ensure appeal resolution notices are sent via certified mail.*	✓		✓

METHODOLOGY

The process Constellation Quality Health used for the External Quality Review (EQR) activities was based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the EQR of a Medicaid Managed Care Organization (MCO)/Prepaid Inpatient Health Plan. The process focuses on the four federally mandated EQR activities: compliance determination, validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On July 8, 2024, Constellation sent notification to Select Health 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 Select Health to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from July 22, 2024, and reviewed in Constellation's offices (*see Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the Desk Review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on August 21 and 22, 2024. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Select Health's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between the health plan and the South Carolina Department of Health and Human Services (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 Administration section of the review includes policy and procedure development and management, health plan staffing, information management systems, compliance and program integrity, and processes for ensuring confidentiality.

Select Health develops policies and procedures to ensure compliance with regulations, standards, and contractual requirements. The policies and procedures are reviewed annually and revised as needed, with revised and/or retired policies and procedures retained for at least 10 years. Department leaders educate staff about new and revised policies, and staff can access policies on an internal drive.

Staff reporting and operational relationships are documented on Organizational Charts. Review of the Organizational Charts and onsite discussion confirmed that all required key positions are filled and overall staffing is appropriate for conducting the required health plan activities.

The 2023 Select Health of South Carolina Compliance Program (Compliance Plan) outlines the elements and procedures for ensuring compliance with federal and state regulations and the 2023 Program Integrity Plan for Select Health of South Carolina (Program Integrity Plan) describes processes to monitor, detect, prevent, and investigate fraud, waste, and abuse (FWA). Related policies and procedures provide detailed information about compliance and FWA topics. The responsibilities of the Compliance Officer are addressed in the Compliance Plan, and the Program Integrity Plan addresses the roles and responsibilities of the Program Integrity Officer. In addition, Policy 168.102, Code of Conduct and Ethics and Disciplinary Action, which is given to employees upon hire and annually, provides guidance about ethical behavior and compliance with laws.

Select Health's Compliance Committee provides comprehensive monitoring of the Compliance Program, makes recommendations for the Annual Compliance and Privacy Work Plan, and provides guidance for all compliance activities. The committee meets quarterly, or a minimum of at least three times a year. A quorum is established with the presence of at least 50% of the voting members.

Select Health requires compliance training for members of the Board of Directors, all employees, and subcontractors. For employees, the training is conducted upon employment (prior to being given access to protected information) and then annually. This training addresses federal and state False Claims Acts, the Anti-Kickback Statute, the Deficit Reduction Act, the Fraud Enforcement and Recovery Act, the Health Insurance Portability and Accountability Act, Health Information Technology for Economic and Clinical Health Act, the Code of Conduct, and conflicts of interest. Additional focused training is provided for specific high-risk areas within the organization.

Employees are educated about methods of reporting compliance and/or FWA concerns, and Select Health enforces a policy prohibiting retaliation for good-faith reporting. Reports can be made anonymously through online and telephonic options, and the Compliance Department maintains an open-door policy for employees to discuss any concerns. Select Health publicizes disciplinary guidelines, including consequences for violating the Code of Conduct, to new employees upon hire and annually to all employees.

To evaluate the effectiveness of the Compliance and FWA Programs, Select Health conducts routine monitoring and auditing activities, including an annual risk review of compliance, privacy, and FWA functions to identify risk; use of dashboard reporting to monitor ongoing performance; monitoring subcontractors/vendors to ensure compliance with regulatory and contractual requirements; and use of monitoring and auditing tools to detect and mitigate suspected FWA.

To ensure prompt responses to identified areas of noncompliance, Select Health has developed policies and protocols for internal and external warnings, internal remediation and corrective action initiatives, FWA investigation, and reporting as needed to regulatory bodies. The Compliance Department tracks all remediation/corrective actions, provides updates to the Compliance Committee, and self-reports when necessary to Medicare and Medicaid program leadership, Medicaid Fraud Control Units, law enforcement, and other state and federal regulatory agencies. Select Health also ensures there are no participation exclusions for employees, subcontractors/vendors, and network providers by routinely monitoring federal and state databases for sanctions and exclusions.

Policy MED (PA) 150.402, Beneficiary Lock-In Program, describes processes and requirements for the Pharmacy Lock-In Program that is in place to manage members who have been identified as using services at a frequency or amount that is not medically necessary. The policy addresses the timeframe and methods of notifying members of their inclusion in the program. However, the policy does not specify the timeframe for finalizing the member's pharmacy lock-in once the referral is received from SCDHHS or the timeframe for notifying members by letter of their removal from the program.

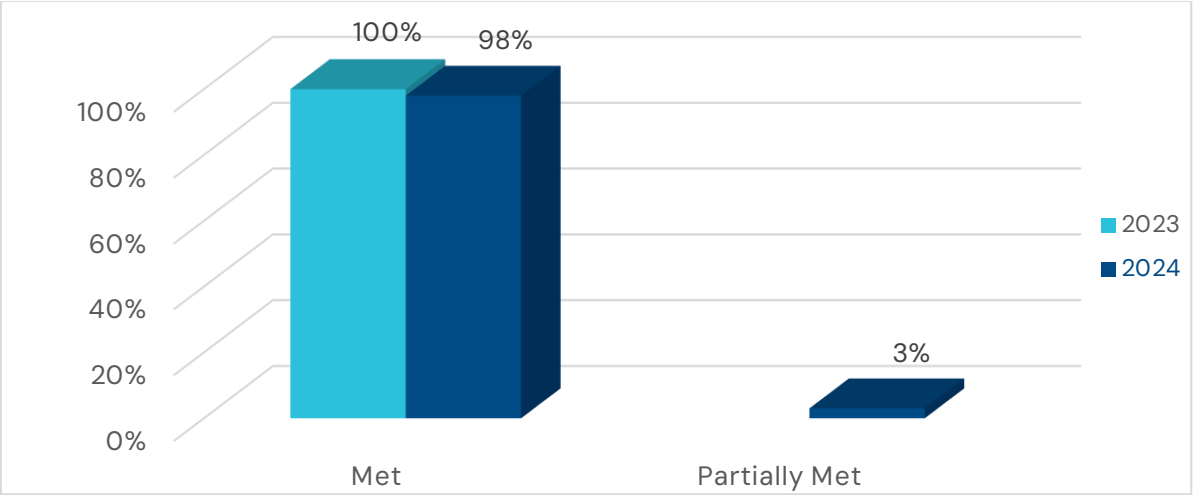
Information Management Systems Assessment

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

Select Health provided documentation that demonstrates established processes for meeting the State's performance requirements while maintaining data confidentiality, integrity, and accessibility. The processes adhere to industry best practices and place an emphasis on security. Related policies and procedures are reviewed regularly and updated as needed. To ensure a disaster or interruption does not stop services, Select Health routinely assesses its Disaster Recovery Plan.

As noted in *Figure 2: Administration Findings*, 98% of the Administration standards were scored as "Met."

Figure 2: Administration Findings



Percentages may not total 100% due to rounding

Table 8: Administration Comparative Data

Section	Standard	2023 Review	2024 Review
Compliance/ Program Integrity	The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 9: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Processes for policy development and ongoing management are appropriate and staff are educated about new/revised policies by departmental leadership.	✓	✓	
All key positions are filled, and overall staffing is appropriate to conduct required health plan activities.	✓		
For information systems, documentation is reviewed on a regular basis and updated as needed. Disaster recovery testing is performed regularly with the most recent test successfully meeting the MCO objectives.	✓		
The Compliance Program and related policies provide detailed information about processes for ensuring compliance with laws and regulations.	✓		
The Code of Conduct is a thorough resource that provides employees with guidance about appropriate business behavior and conduct.	✓		

Strengths	Quality	Timeliness	Access to Care
The Program Integrity Plan and related policies and procedures thoroughly document processes to prevent, monitor for, detect, investigate, and respond to FWA.	✓		

Table 10: Administration Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy MED (PA) 150.402, Beneficiary Lock-In Program, describes processes and requirements for the Pharmacy Lock-In Program. The policy does not specify: • The timeframe for finalizing the restriction to one pharmacy from the date the referral is received from SCDHHS. Refer to the *SCDHHS Contract, Section 11.10.2.2* which specifies this timeframe as no later than 90 calendar days after the initial quarterly referral from SCDHHS, unless the member files an appeal. • The timeframe for notifying members by letter of their removal from the program. The *SCDHHS Contract, Section 11.10.5* requires that members be notified at least 10 days in advance.	*Quality Improvement Plan: Revise Policy MED (PA) 150.402, Beneficiary Lock-In Program, to include the timeframe for finalizing the restriction of a member to one pharmacy once identified by SCDHHS and the timeframe for notifying members by letter of their removal from the program. Refer to the SCDHHS Contract, Section 11.10.2.2 and Section 11.10.5.*		✓	✓

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					Select Health develops policies and procedures to ensure compliance with regulations, standards, and contractual requirements. Prior to implementation, all policies and procedures are approved by the Policy and Procedure Subcommittee of the Compliance Committee. Established policies and procedures are reviewed annually and revised as needed. All revised and/or retired policies and procedures are retained for a minimum of 10 years. Processes for policy and procedure development and ongoing management are found in Policy SHC 168.001, Policy & Procedure Program Management & Format Guidelines. As noted, staff can access policies in a designated folder on an internal drive. Departmental leadership is responsible for educating staff about new and revised policies.
I B. Organizational Chart / Staffing						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
1.2 Chief Financial Officer (CFO);	X					
1.3 *Contract Manager;	X					
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					
1.5.1 Pharmacy Director,	X					
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					
1.7.1 Provider Services Staff,	X					
1.8 *Member Services Manager;	X					
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					
1.10 *Compliance Officer;	X					
1.10.1 *Program Integrity Coordinator;	X					
1.10.2 Compliance/ Program Integrity Staff;	X					
1.10.3*Program Integrity FWA Investigative/Review Staff;	X					
1.11 *Interagency Liaison;	X					
1.12 Legal Staff;	X					
1.13 *Behavioral Health Director.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					Staff reporting and operational relationships are documented on the Organizational Charts.
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					Select Health's Information System Capability Assessments documentation indicates that the payment processing rate aligns with the percentages stipulated in the *SCDHHS Contract*. Furthermore, the MCO reviews unpaid claims daily to ensure the State's performance requirements are being met.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Select Health is able to accept and generate Health Insurance Portability and Accountability Act (HIPAA) compliant electronic transactions. Specifically, Select Health states that Electronic Data Interchange claim data must conform to all HIPAA Strategic National Implementation Process Level 4 standards.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health's systems handle 834 files on a daily basis. In the event of any discrepancies, there are established procedures to guarantee the Enrollment Department achieves a resolution within 24 hours. Furthermore, the systems employed by Select Health are capable of monitoring enrollees who transition between different product lines, as well as tracking and associating prior claim and encounter data across the product lines.
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					Select Health uses dedicated data repository to incorporate all available data. The data repository is used for HEDIS reporting, quality reporting purposes, and occasionally other

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reporting. The MCO runs each transaction file through a comprehensive quality analysis process prior to being merged into the HEDIS data repository. This process involves a series of data queries and visual inspections on the transaction files to ensure that data fields are correctly populated and formatted to meet the repository specifications.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Select Health has policies, procedures, and processes in place for addressing data security as required by the contract. Specifically, the MCO provided documentation demonstrating that the organization adheres to security standards. Furthermore, the organization's information security policy addresses the staff's roles and responsibilities associated with data security.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Select Health has policies, procedures, and processes in place for addressing information security and access management as required by the contract. Specifically, the MCO provided documentation detailing the access management controls that are in place that must be adhered to. These controls extend to physical security, remote access, mobile devices, and system access.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Select Health has an up-to-date disaster recovery plan written to ensure operations are maintained in case of an interruption. The disaster recovery plan is reviewed and updated regularly to ensure system updates and changes are included. The plan was recently tested, and it successfully met the MCO's recovery-time-objectives and recovery-point-objectives.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Select Health provided copies of the: • 2023 Select Health of South Carolina Compliance Program (Compliance Plan), which outlines the elements and procedures for ensuring compliance with federal and state regulations • 2023 Program Integrity Plan for Select Health of South Carolina (Program Integrity Plan), which addresses strategies to prevent, detect, investigate, and mitigate fraud, waste, and abuse in healthcare services Related policies, procedures, and other documents provide detailed information about compliance and FWA topics.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Policy 168.102, Code of Conduct and Ethics and Disciplinary Action, which will be referenced as the Code of Conduct, provides guidance about

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ethical behavior and compliance with laws for all employees and the Board of Directors. The Code of Conduct addresses topics including but not limited to: • Standards for legal and ethical conduct within the company • Setting standards for expected conduct, monitoring compliance, and enforcing corrective actions • Definitions of relative terminology • Dissemination of and training on the Code of Conduct • The responsibility of the Corporate Compliance department for developing and maintaining the Code of Conduct • Disciplinary actions that may result from noncompliance with the Code of Conduct The Code of Conduct is provided to associates and subcontractors/vendors at the time of employment and then annually and to the Board of Directors annually.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The responsibilities of the Compliance Officer are addressed in the Compliance Plan. The Program Integrity Plan addresses the roles and responsibilities of the Program Integrity Officer.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						Various organizational charts are included in the Compliance Plan Matrix, including Encounters, Claims, Provider Enrollment Services, Legal, Special

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Investigative Unit (SIU), and Corporate Compliance and Privacy.
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						As noted in the Compliance Plan, compliance training is mandatory for members of the Board of Directors, all employees, and subcontractors. The training includes federal and state False Claims Acts, the Anti-Kickback Statute, the Deficit Reduction Act, the Fraud Enforcement and Recovery Act, HIPAA, Health Information Technology for Economic and Clinical Health Act, the Code of Conduct, and conflicts of interest. Formal compliance training is conducted for new employees and annually for all employees. Focused training is provided for specific high-risk areas, ethical and legal compliance issues, and resources for compliance educational programs. Additional informal training is provided through compliance communications, Compliance Week events, email alerts, and intranet resources.
2.6 Lines of communication;						Processes and mechanisms for maintaining effective lines of communication are addressed in the Compliance Plan. Select Health enforces a policy prohibiting retaliation for good faith reporting of compliance

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and FWA issues and offers both online and telephonic options for anonymously reporting compliance, privacy or security concerns and FWA allegations. In addition, reports may be made to telephone hotlines, and the Compliance Department maintains an open-door policy for associates to discuss concerns with Compliance staff. Select Health posts contact information for reporting concerns throughout its offices and distributes the information through compliance education activities and communications. Policy 168.103, Compliance Tools for Effective Lines of Communication, provides additional information establishment, maintenance, and communication of options available to staff and others for reporting compliance and/or FWA concerns, processes for logging and maintaining reports received, and includes references to related policies and procedures.
2.7 Enforcement and accessibility;						Select Health enforces compliance and ethical standards by publicizing disciplinary guidelines that include consequences for violating the Code of Conduct. As noted in the Compliance Plan, this information is disseminated to new employees upon hire and annually to all employees through training

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						activities and is available on the corporate intranet.
2.8 Internal monitoring and auditing;						Routine monitoring and auditing activities include: • An annual risk review of compliance, privacy, and FWA functions within Select Health to identify potential risk to contractual compliance and to the integrity of the Compliance Program. The annual risk review aids in the definition, development, and implementation of appropriate oversight. • Development and implementation of dashboard reporting to monitor ongoing performance, prioritized according to risk, and distributed to the market Compliance Officer and Market President. • Monitoring subcontractors/vendors to ensure compliance with regulatory and contractual requirements and to identify the need for corrective actions. • Use of monitoring and auditing tools to detect and mitigate suspected FWA. These include validating provider eligibility, monitoring claims for aberrant patterns, conducting pre-payment review of providers suspected of FWA, and retrospective claims review for payment propriety. Policy SHC 168.002, Compliance Auditing and Monitoring, provides

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						additional details about auditing and monitoring activities to ensure compliance with laws, regulations, and the Code of Conduct.
2.9 Response to offenses and corrective action;						To ensure prompt responses to identified areas of noncompliance, Select Health has developed policies and protocols for internal and external warnings, internal remediation and corrective action initiatives, protocols for FWA investigation, and reporting as needed to regulatory bodies. Remediation and corrective action plans resulting from monitoring, auditing, and investigative activities are designed to address root cause analyses and to quantify and/or identify potential member/provider impact, immediate steps to address the issue, and methods to prevent recurrence. The Compliance Department tracks all remediation/corrective actions and provides updates to the Compliance Committee. Select Health self-reports when necessary to Medicare and Medicaid program leadership, Medicaid Fraud Control Units, law enforcement, and other state and federal regulatory agencies when appropriate or required.
2.10 Data mining, analysis, and reporting;						Data mining, analysis, and reporting activities are addressed in the Program Integrity Plan. Data mining involves both prospective and retrospective analysis of claims data to ensure accuracy, detect potential fraud or abuse, and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recover overpayments. These activities include: • Prospective data mining, through which internal and external vendor resources are used to conduct claims edits to increase the accuracy of provider claims payments. • Retrospective data mining and recovery operations to identify waste and potential overcharges after payments have been made. The internal Payment Integrity Data Analytics Team conducts bi-weekly data mining for retrospective claim overpayments, and external vendors are also involved in data mining to identify potential overpayments. • Recovery processes, in which overpayment request letters are sent to providers with descriptions of the overpayments. Payment recovery is often through offsetting of future claim payments.
2.11 Exclusion status monitoring.						Per the Compliance Plan, Select Health ensures there are no participation exclusions for employees, subcontractors/vendors, and network providers. Monitoring for each of these is conducted upon hire or engagement and then monthly thereafter. Queries conducted include: • The Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE)

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The System for Award Management (SAM) • State exclusion and sanction lists • The Social Security Death Master file (SSDMF) • The National Plan and Provider Enumeration System (NPPES) The Program Integrity Plan also addresses processes for determining exclusion status and ongoing monitoring for employees through pre-employment background checks, drug screenings, and vendor screening against the LEIE and SAM.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					As discussed in the Compliance Plan, Select Health's Compliance Committee provides comprehensive monitoring of the Compliance Program, makes recommendations for the Annual Compliance and Privacy Work Plan, and provides guidance for all compliance activities. The Compliance Committee meets quarterly or at least three times a year. Voting membership of the committee includes senior leadership with the Compliance Officer holding the tie-breaking vote. The Select Health of South Carolina (SHSC) Compliance & Privacy Committee Charter confirms the meeting frequency as quarterly, or at least three times per year, and states the quorum is established with the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						presence of at least 50% of the voting members.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Program Integrity Department is responsible for preventing, detecting, investigating, and reporting FWA. Within the Program Integrity Department, the SIU investigates reports of potential member and provider fraud and abuse activities and refers suspected or confirmed cases to applicable oversight agencies. Policy 106.100.008, Fraud and Abuse Investigations, guides staff in conducting these investigations. The policy includes investigation timelines and elements, auditing and monitoring, and collaboration with external agencies. A policy attachment specifies SC-specific requirements for fraud and abuse investigations. Policy 168.104, Compliance Investigations, Inquiries and Non-retaliation Policy, addresses processes for conducting investigations related compliance issues, misconduct, etc., and disclosure to external entities, such as law enforcement, state, and/or federal agencies.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					As noted in Policy 106.400.001, Recovery Project Submission and Processing, the Program Integrity Department is responsible for managing

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider overpayment recovery processes. Recovery projects are tracked and monitored through the Claims Overpayment Recovery System. Providers are notified via overpayment notification letters that include claim details prior to adjustments being made. Policy 106.700.001, Credit Balance Recovery, addresses processes for recovery of credit balances resulting from claim reversals that create a negative account balance for a provider. Policy 106.100.015, Provider Payment Suspension, addresses the enterprise-wide process for implementing and removing provider payment suspensions when a State detects fraud. An attachment to the policy addresses SC-specific requirements.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).		X				Policy MED (PA) 150.402, Beneficiary Lock-In Program, describes processes and requirements for the Pharmacy Lock-In Program, established to manage members who have been identified as using services at a frequency or amount that is not medically necessary. SCDHHS identifies members through Surveillance and Utilization Review System (SUR) reporting and provides a list of identified members to Select Health on a quarterly basis. Once received, a Medical Director or a Clinical

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Pharmacist reviews the identified members for the appropriateness of inclusion in the program. When selected for inclusion, members are restricted to one designated pharmacy for two years. The policy addresses the timeframe and methods of notifying members of their inclusion in the program. The notification includes the designated pharmacy the member must use, how and when to select a different pharmacy, and the member's appeal rights. Members may use a different pharmacy under specific circumstances and may be given a three-day emergency supply of medication after normal business hours, on weekends, and holidays. Policy MED (PA) 150.402 does not specify: • The timeframe for finalizing the restriction to one pharmacy from the date the referral is received from SCDHHS. Refer to the *SCDHHS Contract, Section 11.10.2.2* which specifies this timeframe as no later than 90 calendar days after the initial quarterly referral from SCDHHS, as long as the member does not file an appeal. • The timeframe for notifying members by letter of their removal from the program. The *SCDHHS Contract, Section 11.10.5* requires that members be notified at least 10 days in advance.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Revise Policy MED (PA) 150.402, Beneficiary Lock-In Program, to include the timeframe for finalizing the restriction of a member to one pharmacy once identified by SCDHHS and the timeframe for notifying members by letter of their removal from the program. Refer to the SCDHHS Contract, Section 11.10.2.2 and Section 11.10.5.
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 168.101, Confidentiality, addresses Select Health's procedures for ensuring the protection of confidential information, including protected health information (PHI). The policy addresses requirements for both use and disclosure of confidential information and includes an extensive list of information that should be considered confidential. As noted in the policy, all employees, contractors, and members of the Board of Directors must sign the Confidentiality, Privacy and Security Agreement during the onboarding process and annually thereafter. This Agreement certifies that they have read, understood, and will abide by policies and procedures regarding confidentiality.

B. Provider Services

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

The Provider Services review includes credentialing and recredentialing processes and file review, provider education processes, preventive health and clinical practice guidelines, continuity of care, processes for assessing provider compliance with medical record documentation standards, and a validation of network adequacy.

Provider Credentialing and Selection

An overview of Select Health's credentialing and recredentialing processes is found in the Credentialing Program 2024 (Credentialing Program Description). Detailed information about credentialing and recredentialing of practitioners and organizational providers is found in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, and Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process. Upon review of these documents, it was found that Policy CR.103.SC does not address organizational providers' rights related to credentialing that are specified in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7*. Additionally, the policy does not address the requirement found in the *SCDHHS Contract, Section 2.7.1.1* for providers to be enrolled with SCDHHS as a SC Medicaid provider.

A discrepancy was found in the timeframe for notifying SCDHHS of a credentialing denial due to program integrity-related reasons. Select Health staff stated this notification is made through a monthly report to SCDHHS, while Policy CR.100.SC indicates the notification is made within 15 calendar days, and Policy CR.103.SC indicates the notification is made within 1 business day of discovery.

No issues were found in the samples of initial credentialing and recredentialing files for practitioners. For organizational providers, one file for a dialysis center did not include evidence of the CMS certification, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7.2.4 through Section 2.7.2.5.3*.

Select Health's Credentialing Committee conducts peer reviews to make credentialing determinations. Additional committee responsibilities include reviewing and approving credentialing policies and procedures, ensuring quality care delivery, and maintaining non-discriminatory practices. The Chief Medical Officer or a designee chairs the committee and holds the tie-breaking vote. Meetings are held monthly with a quorum of 51% voting of the membership required. The committee reports to the Quality Assessment Performance Improvement Committee (QAPIC). Voting members of the committee include internal practitioners with specialties of Family Practice, Internal Medicine, and Behavioral Health. External member

specialties include Pediatrics, Family Medicine, Obstetrics and Gynecology, and a Surgeon who attends on an ad hoc basis.

The processes for conducting ongoing provider monitoring for quality of care and service, suspending or terminating practitioners for serious quality of care or service issues, and conducing ongoing monitoring for provider sanctions and exclusions are addressed in additional policies. No issues were identified.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Account Executives conduct initial provider orientation sessions following the Provider Handbook within thirty days of the provider's active status within the network. A checklist is used for orientation and documentation is maintained. Account Executives also conduct ongoing education for providers. This is accomplished though letters/mailings, Provider Manual updates, information relayed through Provider Relations, newsletters, etc. Training sessions can be conducted in-office or virtually and are documented via the Provider Encounter Form. Correspondence records are maintained, and trends are monitored by the Account Executive and reported to the Director and/or Manager of Network Management for necessary action. These processes are described in Policy NM 159.102, Provider Orientation and Ongoing Training.

The Provider Manual is a resource that provides information needed for providers to function within Select Health's network. It provides an overview of the structure of the health plan and addresses covered benefits and programs, claims and payments, preventive health services for children and adults, specialist referrals, pharmacy information, etc. Circumstances under which a primary care physician (PCP) may request member reassignment are found in the Provider Manual. The health plan's website is also a comprehensive resource for providers.

Select Health adopts and implements Clinical Practice Guidelines (CPGs) and Preventive Health Guidelines (PHGs), as outlined in Policy 391.1003, Preventative and Clinical Practice Guidelines (Admin. Policy). The guidelines are adopted from national sources based on member needs, common health conditions, and member population concerns. The guidelines are reviewed regularly by board-certified practitioners and approved by the Clinical Policy Committee quarterly and as needed. Providers are educated about the guidelines and can access the guidelines on the health plan's website. Hard copies are available upon request.

Select Health educates providers about requirements for medical record documentation, maintenance, storage, and confidentiality. Provider compliance with these requirements is assessed through an annual medical record audit conducted along with the annual Healthcare Effectiveness Data and Information Set (HEDIS) audit, as described in Policy QI 154.009, Medical

Record Review. The policy and the related Medical Record Audit Tool are compliant with the medical record documentation standards defined in the *SCDHHS Policy & Procedure Guide for Managed Care Organizations, Section 15.9 (O)*. Results of the medical record audits are used to determine the need for additional provider education, to share best practices, etc. The Quality Management Department calculates results for each practitioner office included in the audit, with the scoring benchmark set at ≥ 90%. Practices that do not meet the benchmark are notified and a follow-up review is scheduled within 120 days. For continued deficiencies, a corrective action plan is implemented, and a final review is scheduled. An annual summary of performance is reported to the Quality of Clinical Care Committee (QCCC) for review and recommendations.

The Quality Management Department also tracks continuity and coordination of care and presents an annual report to the QAPIC as part of Quality Improvement Program Evaluation. The QAPIC initiates action to address identified continuity and coordination of care issues. The March 2024 QCCC minute packet includes the summary and full Continuity and Coordination between Medical and Behavioral Healthcare for 2023. A summary of the Continuity and Coordination of Medical Care Report was found in the August 2023 QAPIC meeting packet (Tab 4.B, Measure 6). A copy of the full Continuity and Coordination of Medical Care Report was requested but was not provided by Select Health.

Network Adequacy Validation

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

Constellation conducted a validation review of Select Health's provider network following the CMS protocol titled *EQR Protocol 4: Validation of Network Adequacy*. This protocol validates the health plan's provider network to determine if the MCO meets network standards defined by the State. To conduct this validation, Constellation requested and reviewed the following:

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

- Sample of a provider contract

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

Provider Network File Questionnaire

Through review of the Provider Network File Questionnaire, it was found that provider enrollment systems are maintained though a collaborative inter-departmental effort, including Provider Network Management, Provider Network Operations, and Provider Enrollment Services. Select Health uses Facets as the data management system with a separate database (LIFT) being added to track communication between providers and staff. Account Executives validate provider data, and the online Provider Directory is updated daily.

Availability of Services

The review revealed inconsistencies in the geographic access standard for PCPs and specialists when comparing Policy NM 159.206, Availability of Practitioners, and the Annual Assessment of Network Adequacy and Network Development Report (completed July 2024).

- Policy NM 159.206 states the geographic access standard for PCPs is ≥95% of members with access to one provider within 30 miles. The policy states the geographic access standard for specialists is ≥95% of members with access to one provider within 50 miles.
- The Annual Assessment of Network Adequacy and Network Development Report states the standard for PCPs is ≥95% of members with access to two practitioners within 30 miles. It states the standard for specialists as ≥95% of members with access to two practitioners within 50 miles.

Select Health staff reported that they are using the higher standards listed in the Annual Assessment of Network Adequacy and Network Development Report. This was confirmed through review of the Geo Access reports submitted by Select Health. The Geo Access reports also reflected that Select Health contracts with all required Status 1 and Status 2 provider types. Account Executives monitor and validate providers' panel status through an annual provider directory accuracy survey and a monthly sampling review of data accuracy. The health plan reports that there are currently only 25 practices that are not accepting new patients.

As noted in the Network Development Plan, Select Health addresses identified network adequacy opportunities through a provider outreach strategy that includes researching prospective provider availability, confirming prospective providers are enrolled with SCDHHS, validating prospective providers will provide the needed services, and extending a participation agreement to prospective providers.

Appointment access standards are defined in Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, and in the Provider Manual. Select Health assesses provider compliance with appointment access standards by conducting telephonic surveys of PCPs and high volume/high impact specialists. Noncompliant providers are reviewed by the Provider Network Management team and a corrective action plan is initiated. Survey results are reported annually to the Quality of Service Committee (QSC) and QAPIC. The 2023 Network Development Plan indicates goals of 100% were met for PCP routine and urgent care appointments and specialty appointments. The goal of 100% was not met for after-hours access; however, the 2023 score was 99.9%.

In addition to monitoring geographic adequacy and appointment access, Select Health monitors its network's ability to serve members with special needs and cultural requirements by collecting and evaluating provider race, ethnicity, and language data and abilities to accommodate members with mental and/or physical disabilities. Provider and office support staff languages are included in the Provider Directory. Select Health's website includes general cultural competency information and additional resources for providers. An overview of cultural competency is included in the Provider Manual.

Select Health maintains a printed (PDF) Provider Directory and the website offers an online directory that includes the ability to search for providers. The review found that neither of Select Health's Provider Directories includes dispensing pharmacies, as required by the *SCDHHS Contract, Section 3.12.3.3*. On the "Member Tools" page on Select Health's website, a hyperlink directs the user to a document titled "First ChoiceSM by Select Health of South Carolina Pharmacy List;" however, this list is outdated (March 2023) and appears to be large Excel spreadsheets saved as a PDF. The page size may be increased to make it readable online, but the document would not be readable if printed due to the amount of information on each page. A hyperlink to an external website that includes a searchable pharmacy directory is also found on the "Member Tools" page. However, this may be difficult to locate because the Member Handbook, page 15, states, "For a directory of participating First Choice providers, go to www.selecthealthofsc.com, and click on Find a Provider." Upon review, it was found that the "Find a Doctor" page of the website does not direct the user to the section of the website that may be used to search for participating pharmacies.

Policy NM 159.308, Assessment of Physician Directory Accuracy, describes processes for validating information in provider directories through an annual online Provider Directory audit. Results are reported to the QSC. This report was last presented to the QSC in the Spring of 2024. Review of the report revealed the goal for Provider Directory accuracy is 85% and that four of the five audit elements surveyed exceeded the goal. Barriers and interventions to address the goal that was not met were included.

Provider Access and Availability Study

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

As part of the annual EQR process for Select Health, a provider access study focusing on primary care providers was conducted. From a list of current providers supplied by Select Health, a population of 1,956 PCPs was identified, and a random sample of 173 PCPs was selected for the provider access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the providers. For the Telephone Provider Access Study conducted by Constellation, calls were successfully answered 47% of the time (75 out of 161) when omitting calls answered by personal or general voicemail messaging services. The success rate declined from last year's rate of 55%. This represents a non-significant decrease in successful calls (p = .133). See *Table 11*.

Table 11: Telephonic Access Study Answer Rate Comparison

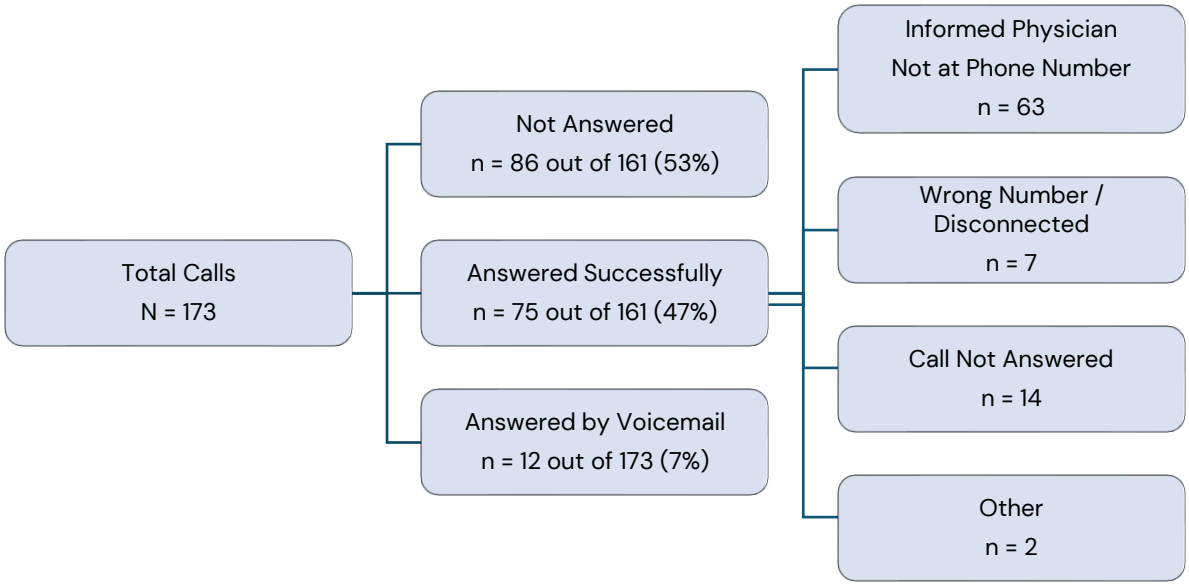
Review Year	Sample Size	Answer Rate	Fisher's Exact p-value
2023 Review	210	55% (107 out of 193)	.133
2024 Review	173	47% (75 out of 161)	

For calls not answered successfully (n= 86), 63 (73%) were due to the physician no longer being active at that location; seven (8%) were due to a wrong number, hold time longer than five minutes, or busy signal; and 14 (16%) were due to the call not being answered. Of 75 providers successfully contacted, 64 (86%) accepted Select health and 11 (14%) did not accept Select Health. Of the 64 who are accepting Select Health, 37 (58%) are accepting new patients while 27 (42%) are not accepting new patients.

A routine appointment was available within the contractual requirement of 30 days for 23 (62%) of the 37 providers that are accepting new patients. Appointment availability could not be determined for 14 (38%) of the 37 that are accepting new patients due to the provider's office requiring patient information for appointment scheduling.

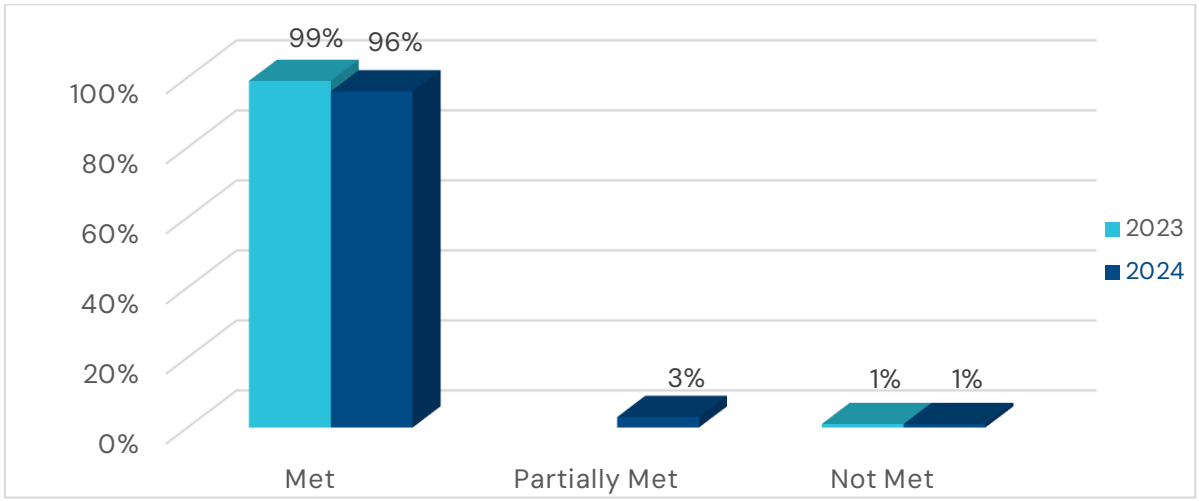
Results of the call study are displayed in *Figure 3: Telephonic Provider Access Study Results*.

Figure 3. Provider Access Study Results



As noted in *Figure 4: Provider Services Findings*, 96% of the standards in the Provider Services section were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 12: Provider Services Comparative Data

Section	Standard	2023 Review	2024 Review
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met
Adequacy of the Provider Network	The MCO regularly maintains and makes available a Provider Directory that includes all required elements	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 13: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
The Credentialing Committee uses a peer review process to make credentialing determinations. Committee member specialties include Family Practice, Internal Medicine, Pediatrics, Obstetrics and Gynecology, Behavioral Health, and a Surgeon who attends on an ad hoc basis.	✓		✓
No issues were found in the initial credentialing and recredentialing files for practitioners.	✓		
Select Health conducts appropriate activities to monitor providers for quality of care and quality of services issues and takes action to address any identified issues.	✓		✓
Ongoing monitoring is conducted to determine if network providers have any sanctions or exclusions that would prohibit their participation in the network.	✓		✓
Select Health uses appropriate geographic access standards for network providers, and contracts with all required Status 1 and Status 2 provider types.			✓
Providers are educated about cultural competency and Select Health evaluates its network's ability to meet the cultural, diversity, and other special needs of members.	✓		✓
The health plan evaluates provider compliance with appointment access standards and takes action to address any identified issues.	✓		✓
Initial and ongoing provider education is comprehensive.	✓		✓
Appropriate processes are in place for adoption and ongoing review of preventive health and clinical practice guidelines. Providers can access the guidelines on Select Health's website and can get hard copies upon request.	✓		✓
Providers are educated about medical record documentation standards and assessed annually for compliance.	✓		

Table 14: Provider Services Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, does not address: • Organizational providers' rights to review information submitted to support the credentialing application, to correct erroneous information, to receive the status of the credentialing or recredentialing application, to a non-discriminatory review, and to receive notification of these rights. • Requirements for providers to be enrolled with SCDHHS as a SC Medicaid provider.	*Quality Improvement Plan: Revise Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, to include providers' rights specified in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7 and to address the requirement for providers to be enrolled with SCDHHS as a SC Medicaid provider, as required by the SCDHHS Contract, Section 2.7.1.1.*	✓		✓
When discussing the timeframe for notifying SCDHHS of a credentialing denial due to program integrity-related reasons, Select Health staff reported that this information is included in a monthly report submitted to the State. However, Policy CR.100.SC indicates SCDHHS is notified within 15 calendar days when credentialing is denied for program integrity-related reasons, and Policy CR.103.SC indicates SCDHHS is notified within one business day of discovery of any for-cause program integrity-related denials or program integrity- related termination of credentialing.	*Quality Improvement Plan: Determine the timeframe within which Select Health will notify SCDHHS of program integrity-related credentialing denials and update Policies CR.100.SC and CR.103.SC to reflect that timeframe.*		✓	
For one initial credentialing file for a dialysis center, verification of the required CMS certification was not evident. Documentation included in the file indicates certification cannot be given until deficiencies are corrected. This was discussed with Select Health during the onsite. After the onsite, Select Health responded that "The credentialing team has reached out to the Provider Network Management Account Executive and Ops Analyst, to see if they'd received a follow up notification or letter confirming the CMS Site Survey CAP was accepted or whether a Plan Site Visit was conducted. "	*Recommendation: Ensure CMS certification is confirmed for provider types for which this is a requirement. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7.2.4 through Section 2.7.2.5.3.*	✓		✓
The review revealed an inconsistency in the geographic access standard for PCPs: • Policy NM 159.206, Availability of Practitioners, states the geographic	*Recommendation: Update Policy NM 159.206, Availability of Practitioners, to reflect that Select Health is using a PCP access standard of ≥95% of members*			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
access standard for PCPs is ≥95% of members with access to one provider within 30 miles. • The Annual Assessment of Network Adequacy and Network Development Report states the standard as ≥95% of members with access to two practitioners within 30 miles. Although the requirement in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2* is that members must have access to at least one PCP within 30 miles, Select Health staff reported that they are using the higher standard of two providers within 30 miles for PCP access.	*with access to two practitioners within 30 miles.*			
An inconsistency in the geographic access standard for specialists was also noted: • Policy NM 159.206, Availability of Practitioners, states the geographic access standard for specialists is ≥95% of members with access to one provider within 50 miles. • The Annual Assessment of Network Adequacy and Network Development Report states the geographic access standard for specialists is ≥95% of members with access to two practitioners within 50 miles. Select Health staff confirmed they are using the standard of two providers within 50 miles for specialist access. This is reflected in the Geo Access report attached to the Annual Assessment of Network Adequacy and Network Development Report.	*Recommendation: Update Policy NM 159.206, Availability of Practitioners, to reflect that the access standard for specialists is ≥95% of members with access to two practitioners within 50 miles.*			✓
The *SCDHHS Contract, Section 3.12.3.3*, requires Provider Directories to "Include, at a minimum, information about the following Providers: (1) Primary Care Providers (PCPs), (2) Specialty and Behavioral Health Providers, (3) Pharmacies, (4) Hospitals, (5) Certified Nurse Midwives, (6) Licensed Midwives, (7) Long Term Support Service (LTSS) Providers and (7) Ancillary Providers."	*Quality Improvement Plan: Include dispensing pharmacies in the printed and online Provider Directories, as required by the SCDHHS Contract, Section 3.12.3.3.*			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Review of Select Health's online and printed Provider Directories revealed neither includes dispensing pharmacies. On the "Member Tools" page on Select Health's website, a "Printable pharmacy network list (PDF)" hyperlink directs the user to a document titled "First Choice℠ by Select Health of South Carolina Pharmacy List;" however, this list is dated March 2023 and appears to be large Excel spreadsheets saved as a PDF. The page size may be increased to make it readable online, but the document would not be readable if printed due to the amount of information saved on each page. A hyperlink to an external website that includes a searchable pharmacy directory is also found on the "Member Tools" page. However, this may be difficult to locate because the Member Handbook, page 15, states, "For a directory of participating First Choice providers, go to www.selecthealthofsc.com, and click on Find a Provider." Upon review, it was found that the "Find a Doctor" page of the website does not direct the user to the section of the website that may be used to search for participating pharmacies.				
For the Provider Access Study conducted by Constellation, the successful contact rate declined from the previous year's rate.	*Quality Improvement Plan: Provide documentation on outreach to providers and the procedures that are in place to update provider contact information and panel status for providers.*			✓

II. PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				An overview of Select Health's credentialing and recredentialing processes is found in the Credentialing Program 2024 (Credentialing Program Description). Select Health has established policies and procedures for credentialing and recredentialing of health care providers, including: • Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing • Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process • Policy CR.112.SC, Credentialing / Recredentialing Provider Denial, Termination or Reconsideration Appeal Process Upon review of these documents, it was found that Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, does not address: • Organizational providers' rights to review information submitted to support the credentialing application, to correct erroneous information, to receive the status of the credentialing or recredentialing application, to a non-discriminatory review, and to receive notification of these rights. Refer to the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7. • Requirements for providers to be enrolled with SCDHHS as a SC Medicaid provider. Refer to the *SCDHHS Contract, Section 2.7.1.1.* *Quality Improvement Plan: Revise Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process, to include providers' rights specified in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7 and to address the requirement for providers to be enrolled with SCDHHS as a SC Medicaid provider, as required by the SCDHHS Contract, Section 2.7.1.1.* When discussing the timeframe for notifying SCDHHS of a credentialing denial due to program integrity-related reasons, Select Health staff reported that this information is included in a monthly report submitted to the State. However, Policy CR.100.SC indicates SCDHHS is notified within 15 calendar days when credentialing is denied for program integrity-related reasons, and Policy CR.103.SC indicates SCDHHS is notified within 1 business day of discovery of any for-cause program integrity-related denials or program integrity-related termination of credentialing. *Quality Improvement Plan: Determine the timeframe within which Select Health will notify SCDHHS of program integrity-related credentialing*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						denials and update Policies CR.100.SC and CR.103.SC to reflect that timeframe.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					As noted in Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, Select Health's Credentialing Committee conducts peer reviews to make credentialing determinations. Additional committee responsibilities include reviewing and approving credentialing policies and procedures, ensuring quality care delivery, and maintaining non-discriminatory practices. The Credentialing Committee reports to QAPIC. The Chief Medical Officer or a designee chairs the committee and holds the tie-breaking vote. Meetings are held monthly with a quorum of 51% voting membership required. The most recent Credentialing Committee Minutes reviewed (6/12/24) indicate committee membership includes internal members with specialties of Family Practice, Internal Medicine, and Behavioral Health. External members include providers with specialties of Pediatrics, Family Medicine, Obstetrics and Gynecology, and a Surgeon who attends on an ad hoc basis.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					No issues were found in the sample of initial credentialing files for practitioners.
3.1 Verification of information on the applicant, including:						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
of Excluded Individuals and Entities (LEIE);						
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.15 Additional Requirements for Nurse Practitioners.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					No issues were identified in the sample of practitioner recredentialing files.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.13 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.14 Additional Requirements for Nurse Practitioners.	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					The processes for ongoing provider monitoring are outlined in Policy CR.104.SC, Ongoing Monitoring – Licensure and Medicare/Medicaid Sanctions. This policy indicates Quality of Care Concerns are reviewed monthly by the Quality Management Department, and findings are presented to the Credentialing Committee as needed for further action. Processes for suspending or terminating practitioners for serious quality of care or service issues are addressed in Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality. The policy details the investigation process, referral to the Credentialing Committee for review, potential actions recommended by the Committee (including termination), and reporting requirements to national and state regulatory agencies.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					For one file for a dialysis center, verification of the required CMS certification was not evident in the file. Documentation in the file indicates certification cannot be given until deficiencies are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						corrected. This was discussed with Select Health during the onsite. After the onsite, Select Health responded that "The credentialing team has reached out to the Provider Network Management Account Executive and Ops Analyst, to see if they'd received a follow up notification or letter confirming the CMS Site Survey CAP was accepted or whether a Plan Site Visit was conducted. " *Recommendation: Ensure CMS certification is confirmed for provider types for which this is a requirement. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.7.2.4 through Section 2.7.2.5.3.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					The processes for conducting ongoing provider monitoring for sanctions and exclusions are outlined in Policy CR.104.SC, Ongoing Monitoring – Licensure and Medicare/Medicaid Sanctions.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1. The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					The review revealed an inconsistency in the geographic access standard for PCPs when comparing Policy NM 159.206, Availability of Practitioners, and the Annual Assessment of Network Adequacy and Network Development Report (completed July 2024). • Policy NM 159.206 states the geographic access standard for PCPs is ≥95% of members with access to one provider within 30 miles.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The Annual Assessment of Network Adequacy and Network Development Report states the standard as ≥95% of members with access to two practitioners within 30 miles. Although the requirement in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2* is that members must have access to at least one PCP within 30 miles, Select Health staff reported that they are using the higher standard of two providers within 30 miles for PCP access. *Recommendation: Update Policy NM 159.206, Availability of Practitioners, to reflect that Select Health is using a PCP access standard of ≥95% of members with access to two practitioners within 30 miles.* The Annual Assessment of Network Adequacy and Network Development Report showed that 100% of members have the required access to Family Medicine, General Practice, and Internal Medicine providers and 99.9% of members have the required access to Pediatrics providers. The Geo Access report confirmed that the correct parameters are used for evaluating access to primary care provider types and that Select Health contracts with the required Status 1 PCP provider types. When asked how the health plan monitors open and closed provider panels within the network, Select Health responded that Account

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Executives "monitor and validate groups with open panels who are accepting new patients through our annual provider directory accuracy survey as well as a monthly sampling review of data accuracy against the online provider directory. Currently, out of 1,200 PCP groups there are only 25 groups that are not accepting new patients."
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					An inconsistency in the geographic access standard for specialists was also noted when comparing Policy NM 159.206, Availability of Practitioners, and the Annual Assessment of Network Adequacy and Network Development Report (completed July 2024). • Policy NM 159.206 states the geographic access standard for specialists is ≥95% of members with access to one provider within 50 miles. • The Annual Assessment of Network Adequacy and Network Development Report states the geographic access standard for specialists is ≥95% of members with access to two practitioners within 50 miles. Although the requirement in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2* is that members must have access to at least one specialist within 50 miles, the *SCDHHS Contract, Section 6.2.3.1.4* requires MCOs to "Make available a choice of at least 2 required contracted specialists and/or subspecialists who are accepting new patients within the geographic area." Select Health staff confirmed they are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						using the standard of two providers within 50 miles for specialist access. This is reflected in the Geo Access report attached to the Annual Assessment of Network Adequacy and Network Development Report. The Geo Access report reflects Select Health contracts with all required Status 1 and Status 2 provider types. *Recommendation: Update Policy NM 159.206, Availability of Practitioners, to reflect that the access standard for specialists is ≥95% of members with access to two practitioners within 50 miles.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Select Health runs quarterly geographic access reports. In addition, Select Health monitors member to provider ratios, member complaints and grievances, out of network requests, etc.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					As noted in Policy NM 159.101, Assessment of Special Needs Provisions and Cultural Responsiveness of the Provider Network, Select Health ensures network providers can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs by: • Requesting provider race, ethnicity, and language data and other information about abilities to accommodate members with mental and/or physical disabilities through provider visits and credentialing/recredentialing processes • Including provider and office support staff languages and other language services offered through provider practices in printed and online Provider Directories

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Select Health's website includes general cultural competency information and additional resources for providers, including: • Cultural and Linguistically Appropriate Services (CLAS) standards • Information about health literacy • Links to cultural competency training on external sites • Information about the CLAS workgroup An overview of cultural competency is included in the Provider Manual.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The Network Development Plan indicates Select Health addresses identified network adequacy opportunities through a provider outreach strategy that includes: • Researching prospective provider availability • Confirming prospective providers are enrolled with SCDHHS • Validating prospective providers will provide the needed services in the provider's service area • Extending a participation agreement and upon approval of participation by the Director of Provider Network Management
1.6 The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					Through review of the Provider Network File Questionnaire, it was found that provider enrollment systems are maintained though a collaborative inter-departmental effort, including Provider Network Management, Provider Network Operations, and Provider Enrollment Services. Select Health uses Facets as the data management system with a

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						separate database (LIFT) being added to track communication between providers and staff. Account Executives validate provider data, and the online Provider Directory is updated daily.
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
2.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Appointment access standards are defined in Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, and in the Provider Manual.
2.2 The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					As addressed in Policy NM 159.203, Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey, Select Health assesses provider compliance with appointment access standards by conducting telephonic surveys of PCPs and high volume/high impact specialists. Providers who do not meet requirements are reviewed by the Provider Network Management team and a corrective action plan is initiated. Survey results are reported annually to the Quality of Service Committee and Quality Assessment and Performance Improvement Committee. The 2023 Network Development Plan indicates goals (100%) were met for PCP routine and urgent care appointments and specialty appointments. The goal of 100% was not met for after-hours access. However, the 2023 score was 99.9%.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.		X				Select Health documents required elements for paper and online Provider Directories in Policy NM 159.308, Assessment of Physician Directory Accuracy. The *SCDHHS Contract, Section 3.12.3.3*, requires Provider Directories to "Include, at a minimum, information about the following Providers: (1) Primary Care Providers (PCPs), (2) Specialty and Behavioral Health Providers, (3) Pharmacies, (4) Hospitals, (5) Certified Nurse Midwives, (6) Licensed Midwives, (7) Long Term Support Service (LTSS) Providers and (7) Ancillary Providers." However, review of the online and printed Provider Directories revealed neither includes dispensing pharmacies. The only pharmacies identified in the directories are those that dispense durable medical equipment and some specialty pharmaceuticals. On the "Member Tools" page on Select Health's website, a "Printable pharmacy network list (PDF)" hyperlink directs the user to a document titled "First Choice℠ by Select Health of South Carolina Pharmacy List;" however, this list is dated March 2023 and appears to be large Excel spreadsheets saved as a PDF. The page size may be increased to make it readable online, but the document would not be readable if printed due to the amount of information on each page.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A hyperlink to an external website that includes a searchable pharmacy directory is also found on the "Member Tools" page. However, this may be difficult to locate because the Member Handbook, page 15, states, "For a directory of participating First Choice providers, go to www.selecthealthofsc.com, and click on Find a Provider." Upon review, it was found that the "Find a Doctor" page of the website does not direct the user to the section of the website that may be used to search for participating pharmacies. *Quality Improvement Plan: Include dispensing pharmacies in the printed and online Provider Directories, as required by the SCDHHS Contract, Section 3.12.3.3.*
2.4 The MCO conducts appropriate activities to validate Provider Directory information.	X					Policy NM 159.308, Assessment of Physician Directory Accuracy, describes processes for validating information in provider directories. Select Health conducts an annual online Provider Directory audit of a statistically valid sample of providers through in-person, telephonic, or electronic communications. Changes in information are sent to Provider Network Operations to update the provider database. An annual Physician Directory Accuracy report is presented to the QSC. The report includes metrics such as correct addresses/phone numbers, hospital affiliations, acceptance of new patients, and network participation. Onsite discussion revealed this report was last presented to the QSC in the Spring of 2024. After the onsite, Select

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Health provided a copy of the Select Health of South Carolina Provider Directory Accuracy Report. This report indicated the goal for Provider Directory Accuracy is 85% and that four of the five audit elements surveyed exceeded the goal. Barriers and interventions to address the goal that was not met were included.
2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.			X			As part of the annual EQR process for Select Health Plan, a provider access study was conducted that focused on primary care providers. Select Health provides a list of current providers, from which a population of 1,956 unique PCPs was identified. A sample of 173 providers was randomly selected for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. For the Telephone Provider Access Study conducted by Constellation, calls were successfully answered 47% of the time (75 out of 161) when omitting calls answered by personal or general voicemail messaging services. The success rate declined from last year's rate of 55%. This represents a non-significant decrease in successful calls (p = .133). For calls not answered successfully (n= 86), 63 (73%) were due to the physician no longer being active at that location; 7 (8%) were due to a wrong number, hold time longer than 5 minutes,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						or busy signal, and 14 were due to the call not being answered (16%). Of 75 providers successfully contacted, 64 (86%) accepted Select health and 11 (14%) did not accept Select Health. Of the 64 who are accepting Select Health, 37 (58%) are accepting new patients; 27 (42%) are not accepting new patients. A routine appointment was available within the contractual requirement of 30 days for 23 (62%) of the 37 providers that are accepting new patients. Appointment availability could not be determined for 14 (38%) of the 37 that are accepting new patients due to the provider's office requiring patient information for appointment scheduling. *Quality Improvement Plan: Provide documentation about outreach to providers and the procedures that are currently in place to update provider contact information and panel status for providers.*
2.6 The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					SCDHHS has documented time/distance requirements for primary care, obstetrics and gynecology, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. The Information Systems Capabilities Assessment documentation demonstrated that Select Health and its information systems can meet

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the State's requirements. Policies and procedures demonstrate that sound information security practices have been implemented.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Account Executives conduct initial provider orientation and ongoing education activities. A checklist is used for orientation and documentation is maintained. Orientation is conducted following the Provider Handbook and must be completed within thirty days of the provider's active status. These processes are described in Policy NM 159.102, Provider Orientation and Ongoing Training. The Orientation Agenda and Checklist document is attached to the policy.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					The Provider Manual provides an overview of the structure of the health plan and addresses covered benefits and programs.
2.2 Billing and reimbursement practices;	X					The Provider Manual covers provider claims and payments, including filing deadlines and formats, policies and guidelines, third party liability, and a host of additional topics specific to claims and reimbursement.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					Per the Provider Manual, members are encouraged to obtain a PCP referral for

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specialty care, but this is not required. Prior authorization is not required for in-network specialty visits.
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					The Provider Manual includes information about services covered through Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) as well as adult health screenings. Providers are instructed to follow the United States Preventive Services Task Force grade A and B recommendations when providing preventive screenings to members. Providers are also instructed to follow the Advisory Committee on Immunization Practices recommendations for children and adults, and to use the Centers for Disease Control and Prevention age recommendations for vaccines. The Provider Manual specifies the reimbursable codes for adult exams/screenings and specifies the covered adult vaccines.
2.7 Medical record handling, availability, retention, and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					Circumstances under which a PCP may request member reassignment are found in the Provider Manual.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider training is conducted as needed in response to SCDHHS updates, Federal and State mandates, internal requests, provider requests, and survey results. Training methods include letters/mailings, Provider Manual updates, information relayed through Provider Relations, newsletters, etc. Training sessions can be conducted in-office or virtually and are documented via the Provider Encounter Form. Correspondence records are maintained, and trends are monitored by the Account Executive, who reports identified trends to the Director and/or Manager of Network Management for necessary action. These processes are described in Policy NM 159.102, Provider Orientation and Ongoing Training. The Orientation Agenda and Checklist document is attached to the policy.
II D. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health and clinical practice guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy 391.1003, Preventative and Clinical Practice Guidelines (Admin. Policy), outlines the process for adopting and implementing CPGs and PHGs. The guidelines are adopted based on member needs, common health conditions, and member population concerns, and are adopted from national sources. The CPGs and PHGs are reviewed regularly with board-certified practitioners and approved by the Clinical Policy Committee

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						quarterly and as needed due to new scientific evidence or changes in standards of care. Once approved by the Clinical Policy Committee, the Quality Management Department is informed of guideline updates for presentation to the QAPIC.
2. The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members.	X					
3. The guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					As noted in Policy QI 154.011, Monitoring Continuity and Coordination of Care, the Quality Management Department tracks continuity and coordination of care and presents an annual report to the QAPIC as part of QI Program Evaluation. The QAPIC initiates action to address identified continuity and coordination of care issues. Select Health monitors continuity and coordination of care between PCPs and specialists, organizational and ancillary providers, and pharmacy providers. Activities to monitor continuity and coordination of care are conducted at least annually and include, but are not limited to, medical record reviews; analysis of member complaint, grievance, appeal, and transfer data; evaluating practitioner survey responses about communication/coordination of care; monitoring for quality of care concerns; and analysis of member satisfaction survey results related to provider communication and care management. The March 2024 QCCC minute packet includes the summary and full Continuity and Coordination between Medical and Behavioral Healthcare for 2023. A summary of the Continuity and Coordination of Medical Care Report was found in the August 2023 QAPIC meeting packet (Tab 4.B, Measure 6). A copy of the full Continuity and Coordination of Medical Care Report was

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requested but was not provided by Select Health.
II F. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Standards for acceptable member medical record documentation by PCPs are found in Policy QI 154.009, Medical Record Review. This policy also describes processes for conducting an annual evaluation of practitioner compliance with medical record documentation standards and guidelines.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Medical record documentation standards are defined in the *SCDHHS Policy & Procedure Guide for Managed Care Organizations, Section 15.9 (O)*. The Medical Record Audit Tool is included in Policy 154.009. Both the policy and tool contain all required medical record documentation elements. The Provider Manual is a resource for providers to understand the required elements for medical record documentation.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Select Health monitors practitioner compliance with medical record documentation standards and preventive health guidelines through annual audits of a random selection of providers. Results of these audits are used to determine the need for additional provider education, share best practices, etc. The medical record audits are conducted along with the annual HEDIS survey.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Quality Management Department determines the scoring for practitioners and calculates results for each practitioner office included in the sample as well as an overall aggregate score. The scoring benchmark for practitioners is ≥ 90%. Individual Medical Professional and overall performance scores are evaluated using the established benchmark goals. Practices that do not meet the benchmark score are notified in writing of the deficiency and a follow-up review is scheduled. A re-audit is conducted within 120 days to ensure that the deficiencies are corrected. For continued deficiencies, a corrective action plan is implemented, and a final review is scheduled. An annual summary of performance is reported to the QCCC for review and recommendations. In addition to monitoring compliance with documentation standards, Select Health ensures providers are storing records appropriately, safeguarding confidentiality, and following appropriate timeframes for medical record retention.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					The provider contract templates provided for review inform that the health plan must be granted access to member medical records upon request. Further, the Provider Manual states, "Select Health or its designee must receive medical

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						records from you in a timely manner for purposes of HEDIS data collection, NCQA accreditation, medical records documentation audits, and other quality-related activities that comprise our QAPI program."

C. Member Services

42 CFR § 438.56, 42 CFR § 1212, 42 CFR § 438.100, 42 CFR § 438.10, 42 CFR 457.1220, 42 CFR § 457.1207, 42 CFR § 438.3 (j), 42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

Select Health notifies members of their rights and responsibilities in policy, MEM 129.100, Member Rights and Responsibilities, the Member Handbook, website, and in the Quick Start Guide. The Welcome Kit is provided to new members within 14 calendar days from the date of receipt of the eligibility file and includes the Quick Start Guide. Members are provided with information to address a variety of needs in the Member Handbook, member materials, and website.

The Member Handbook describes core benefits, covered services, prior approval requirements, and limitations. Policy MEM 129.105, Member Services Department, indicates that members are informed of changes to benefits 30 days prior to the effective date. However, when changes were made effective February 2024, notification was not sent until the summer edition of the member newsletter. Select Health indicated the health plan was not notified by SCDHHS of this change in benefit in a timely manner to allow for 30-day notification to its members.

The Member Handbook and policies provide information about selecting a PCP, accessing 24-hour care, emergency assistance, and steps to disenroll from the health plan. Members are provided with resources to address chronic health conditions and disease management.

Member Satisfaction Survey

Select Health contracts with a vendor, Press Ganey, to conduct both the child and adult member satisfaction surveys. For the current measure year, the adult response rate was 12.5%, which is a decline from the previous year's rate. For year over year trending, the findings showed improvement in Rating of the Health Plan, Getting Needed Care, Customer Services, Rating of Health Care, Doctor Communication, Coordination of Care, and Rating of Specialists. The largest declines were in Discussion of Cessation Strategies and Rating of Personal Doctors.

The child response rate was 13.1%, which is a decline from last year's rate. Improvement occurred in the areas of Getting Needed Care, Rating of Health Care, Getting Care Quickly, and Doctor Communication. The largest decline was in Rating of Specialists. The Children with Chronic Conditions (CCC) response rate was 15.2%, which is a decline from the previous year's rate. For the CCC population, Rating of Health Plan, Getting Needed Care, Rating of Health Care, Getting Care Quickly, Doctor Communication, and Coordination of Care improved. The largest decline was in Rating of Specialists.

Grievances

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

Processes for filing, acknowledging, and resolving verbal and written grievances are described in Select Health's policy. The definition of a grievance, grievance filing options, and associated timeframes are consistent in policy, the Member Handbook, Provider Manual, and Select Health's website. Grievances are appropriately categorized and monitored for trends, which are reported quarterly to the Quality of Service Committee as reflected in meeting minutes. A copy of an oral grievances log and records of resolution of written grievances will be retained for 10 years as reflected in Select Health's policies.

A sample of grievance files was selected and reviewed for this EQR. All were acknowledged, investigated, and resolved timely with appropriately documented member correspondence. One grievance remains open at the time of the onsite but is within the resolution timeframe. Investigative notes and appropriate acknowledgement documentation were provided for this EQR.

The Member Services standards for the 2024 EQR were 100% "Met."

Figure 5: Member Services Findings

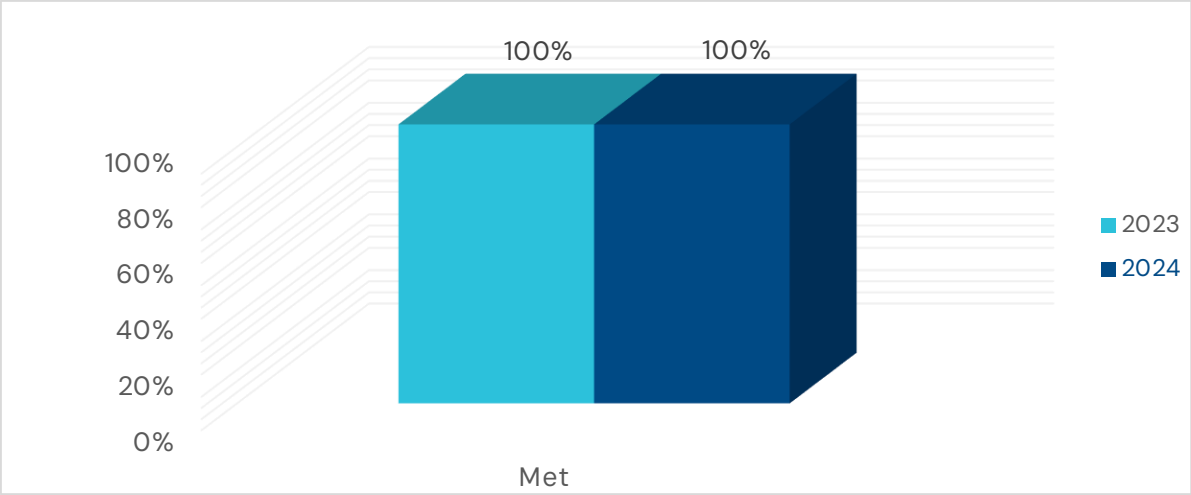


Table 15: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members are informed of their rights and responsibilities in a variety of helpful ways, such as the Member Handbook, Provider Manual, website, and member newsletters.	✓		
The Healthy Now member newsletter provides helpful information to members about programs and available resources.			✓

Strengths	Quality	Timeliness	Access to Care
All grievance files were acknowledged, investigated, and resolved timely with appropriately documented correspondence to members.	✓	✓	

Table 16: Member Services Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
There were noted declines in both adult and child member satisfaction survey response rates reported from the previous year.	*Recommendation: Review the Agency for Healthcare Research and Quality (AHRQ) webcast from January 2024 regarding Consumer Assessment of Healthcare Providers and Systems (CAHPS) response rates, which offers ideas such as promotional material, prenotification letters, and a longer survey collection period.*	✓		

III. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy MEM 129.100, Member Rights and Responsibilities, and Select Health's Quick Start Guide outline each component of the member Bill of Rights and Member Responsibilities, which may be accessed online. Members are made aware of online access to rights and responsibilities in the Healthy Now member newsletter. The Member Handbook lists members' rights and responsibilities.
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					The Quick Start Guide is provided to new enrollees along with the member ID card as part of the Welcome Kit, provided to members within 14 calendar days from the MCO's receipt of enrollment data.
1.1 Benefits and services included and excluded in coverage;						Member deductibles, limits of coverage, and maximum allowable benefits are clearly described in the Member Handbook, Provider Manual, and on the website.
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
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;						
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Processes and requirements related to obtaining prescription medications, including supply limitations and emergency supply of medications, are provided in the Member Handbook, Provider Manual, and website.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The Member Handbook and Quick Start Guide provide information about the role of the PCP, processes for selecting and changing the PCP, and types of providers that can serve as a PCP.
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Policy MEM 129.105, Member Services Department, indicates that members are informed of changes to benefits 30 days prior to the effective date. However, when changes were made effective February 2024, notification was not sent until the summer edition of the member newsletter. Select Health indicated the health plan was not notified by SCDHHS of this change in benefit in a timely manner to allow for 30-day notification to its members.

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					
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					The Member Handbook states the Member Services Call Center is available via a toll-free telephone number from 8 am to 6 pm Monday through Friday. The call center is available on weekends from 8:30 am to 5 pm for pharmacy-related calls. The 24/7 Nurse Call Line is available via a toll-free telephone number around the clock for medical advice.
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					
2. The MCO identifies children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Select Health contracts with Press Ganey, a certified vendor, to conduct the adult, child, and CCC member satisfaction surveys. Press Ganey acquired SPH analytics.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Press Ganey summarizes and details all results from adult and child surveys. *Recommendation: Review AHRQ webcast from January 2024 regarding CAHPS response rates, which offers ideas such as promotional*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						material, prenotification letters, and a longer survey collection period.
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					A provider notification was requested after the onsite. Select Health responded noting that they had just received the results, and they are working on member and provider notification that will go out no later than September for providers.
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					Presented to QSC in August and additional analyses in December 2023.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Processes for handling grievances are outlined in Policy MMS.100, Member Grievances and Appeals Process, the Member Handbook, Provider Manual, and on Select Health's website.
1.1 The definition of a grievance and who may file a grievance;	X					A grievance is clearly defined in written and electronic information for members and providers as not being satisfied with any matter other than an adverse benefit determination.
1.2 Procedures for filing and handling a grievance;	X					Steps for filing and processing grievances are clearly outlined in policy, member materials, and provider materials, from the receipt, to acknowledgment, investigation, options, and through the resolution of grievances.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;	X					
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Policy MMS.100, Member Grievances and Appeals Process, indicates that oral grievance logs and records of resolution of written grievances are retained for 10 years.
2. The MCO applies grievance policies and procedures as formulated.	X					All grievance files were acknowledged, investigated, and resolved timely with appropriately documented correspondence to members. One grievance remains open at the time of the onsite but is within the resolution timeframe. Investigative notes and appropriate acknowledgement documentation were provided for this EQR.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are logged, appropriately categorized, and monitored for trends, which are reported quarterly to the Quality of Service Committee as reflected in committee minutes.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

D. Quality Improvement

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

Select Health's Quality Improvement (QI) program is described in the Quality Management Program Description for 2024 by Select Health of South Carolina. This document highlights the commitment to providing high-quality healthcare services through initiatives like HEDIS performance measures, preventive programs, and population health management. The program focuses on member satisfaction, access to care, and improved health outcomes.

The Program Description provides a comprehensive outline of the program's structure and lines of responsibility. It details the roles and responsibilities of various committees, departments, and key positions involved in overseeing quality improvement activities, monitoring performance, conducting audits, and ensuring compliance with standards. The document also specifies the delegation of health plan functions to subcontractors, the reporting relationships, and the involvement of different stakeholders in ensuring the quality of care and services provided to members.

Information regarding the QI Program was found on Select Health's website. However, this information was outdated. The QI goals shared with providers were the 2023 program goals and the goals shared with members were the 2022 program goals.

Annually, Select Health develops a QI Work Plan to guide the implementation, tracking, and reporting of QI activities. The 2023 and 2024 Work Plans were provided for this EQR. Both work plans encompassed various QI activities such as program documents; quality of clinical care; safety; quality of services; member experience; committee and department reports; and accreditation. The work plan tracks progress for each activity and is updated as needed.

The Quality Assessment and Performance Improvement Committee is a vital entity responsible for overseeing the QI Program. This committee plays a key role in developing, implementing, monitoring, and evaluating the program. The committee structure and responsibilities are outlined in the committee charter. Some of this committee's responsibilities include:

- Assuring integration of QI activities throughout the health plan
- Reviewing and suggesting new and/or improved QI activities
- Monitoring and evaluating the utilization of health services and the effectiveness of the Utilization Management (UM) activities
- Assessing the effectiveness of performance improvement projects through analysis and evaluation of results, initiating needed action, and following up as appropriate

The Quality Clinical Care Committee and the Quality of Service Committee are subcommittees of the QAPIC. Both subcommittees provide direction and oversight of their respective areas of clinical and service QI activities.

The QAPIC is chaired by the Market President. Membership includes leadership in various areas of the organization such as quality management, utilization management, provider services, member services, pharmacy, and behavioral health. Five external healthcare providers and specialists are included as external voting members. The QAPIC meets bi-monthly or at a minimum of five times a year. A quorum is established upon attendance of at least 50 percent of voting members. Committee minutes are recorded at each meeting and reflect key discussion points, decisions made, rationale, planned actions, responsible person, and follow-up. The committee minutes provided demonstrated the committee met bi-monthly in 2023 and a quorum was established before starting the agenda.

Select Health provides direct feedback to PCPs on their performance via a provider report card. The report card offers direct feedback on key quality measures compared to a peer group within the Select Health network. The report cards track progress and help identify areas for improvement. PCPs can access reports on their assigned members through the secure Provider Portal (NaviNet). Policy QI 154.006, EPSDT/Prevention Screening Outreach, and Policy QI 154.014, Monitoring Foster Care Membership Utilization and Compliance with Well Care Visits, describe how Select Health tracks member and provider compliance with EPSDT services. This includes notification of members and providers about age-appropriate and relevant preventive health screenings and services, as well as tracking when members did not receive recommended assessments and/or treatments. Member and Provider Incentive Programs are offered by Select Health to encourage and reward members and providers for engaging in specific health-related activities and behaviors.

Select Health conducts an annual evaluation of the QI Program which involves various aspects such as clinical performance, quality studies, and activities. The evaluation includes assessing effectiveness, identifying areas for improvement, and proposing goals for the following year. This evaluation is initiated by the Quality Department and submitted to the QAPIC for review and approval. The Quality Management Program Evaluation of Calendar Year 2022 was submitted. Select Health indicated they were in the process of completing the 2023 QI Program Evaluation. The health plan anticipates this evaluation will be completed and submitted to the QAPIC for review and approval on August 24, 2024.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation conducted a validation review of the HEDIS measures following the CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. Select Health uses Inovalon, a certified software organization, for calculation of HEDIS rates. Healthcare Data Company, LLC audited the rates. The performance measure validation found that Select Health was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

As part of the review, Constellation examined the roadmap, the data sources, the audit report, and conducted a trend analysis to assess for substantial declines or increases in the rates. All relevant HEDIS performance measures (PMs) for the current measure year (MY2023), the previous measure year (MY2022), and the change from 2022 to 2023 are reported in *Table 17: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial improvement (>10%) and rate changes shown in red indicate a substantial decrease (>10%).

Table 17: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile (Total)	70.34%	74.19%	3.9%
Counseling for Nutrition (Total)	59.32%	60.30%	1.0%
Counseling for Physical Activity (Total)	57.06%	57.32%	0.3%
Childhood Immunization Status (CIS)			
DTaP	73.48%	75.91%	2.4%
IPV	87.59%	88.56%	1.0%
MMR	87.59%	89.78%	2.2%
HiB	82.24%	85.16%	2.9%
Hepatitis B	87.35%	86.13%	-1.2%
VZV	86.13%	88.81%	2.7%
Pneumococcal Conjugate	73.24%	78.35%	5.1%
Hepatitis A	86.62%	87.59%	1.0%
Rotavirus	71.05%	72.75%	1.7%
Influenza	33.09%	29.93%	-3.2%
Combination #3	64.72%	69.59%	4.9%
Combination #7	55.96%	59.37%	3.4%
Combination #10	26.52%	22.38%	-4.1%

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Immunizations for Adolescents (IMA)			
Meningococcal	77.37%	74.32%	-3.1%
Tdap/Td	86.62%	86.54%	-0.1%
HPV	37.71%	34.59%	-3.1%
Combination #1	76.64%	73.99%	-2.7%
Combination #2	36.50%	33.78%	-2.7%
Lead Screening in Children (LSC)	65.85%	67.55%	1.7%
Cervical Cancer Screening (CCS)	62.28%	61.86%	-0.4%
Colorectal Cancer Screening (COL)			
Total	40.56%	43.60%	3.0%
Chlamydia Screening in Women (CHL)			
Total	60.29%	60.05%	-0.2%
Topical Fluoride for Children (TFC)			
(1-2)	NR	22.47%	NA
(3-4)	NR	27.29%	NA
(Total)	NR	24.79%	NA
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)			
Total	82.40%	88.75%	6.4%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	29.93%	26.25%	-3.7%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	70.53%	68.61%	-1.9%
Bronchodilator	79.57%	85.81%	6.2%
Asthma Medication Ratio (AMR)			
Total	70.32%	71.84%	1.5%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	52.01%	59.27%	7.3%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	66.67%	55.88%	-10.8%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
Received Statin Therapy - Total	81.65%	81.96%	0.3%
Statin Adherence 80% - Total	62.14%	65.36%	3.2%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	2.99%	3.45%	0.5%
Cardiac Rehabilitation - Engagement1 (Total)	4.27%	3.45%	-0.8%
Cardiac Rehabilitation - Engagement2 (Total)	4.27%	3.45%	-0.8%
Cardiac Rehabilitation - Achievement (Total)	1.71%	1.48%	-0.2%
Effectiveness of Care: Diabetes			

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Hemoglobin A1c Control for Patients With Diabetes (HBD)			
HbA1c Control (<8%)	42.09%	50.12%	8.0%
***Poor HbA1c Control*	50.85%	40.39%	-10.5%
Blood Pressure Control for Patients With Diabetes (BPD)	61.31%	61.56%	0.3%
Eye Exam for Patients With Diabetes (EED)	47.45%	50.12%	2.7%
Kidney Health Evaluation for Patients With Diabetes (KED)			
Kidney Health Evaluation for Patients With Diabetes (Total)	24.53%	31.60%	7.1%
Statin Therapy for Patients With Diabetes (SPD)			
Received Statin Therapy	60.41%	60.12%	-0.3%
Statin Adherence 80%	56.29%	59.40%	3.1%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (Total)	28.02%	29.75%	1.73%
Antidepressant Medication Management (AMN)			
Effective Acute Phase Treatment	48.26%	52.23%	4.0%
Effective Continuation Phase Treatment	30.14%	34.49%	4.4%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	42.49%	44.55%	2.1%
Continuation and Maintenance (C&M) Phase	57.05%	53.46%	-3.6%
Follow-Up After Hospitalization for Mental Illness (FUH)			
Total - 30-Day Follow-Up	64.36%	64.72%	0.4%
Total - 7-Day Follow-Up	38.24%	39.64%	1.4%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Total - 30-Day Follow-Up	61.33%	60.87%	-0.5%
Total - 7-Day Follow-Up	46.58%	43.99%	-2.6%
Diagnosed Substance Use Disorders (DSU)			
Diagnosed Substance Use Disorders - Alcohol (Total)	1.19%	1.13%	-0.1%
Diagnosed Substance Use Disorders - Opioid (Total)	1.24%	1.19%	0.0%
Diagnosed Substance Use Disorders - Other (Total)	2.48%	2.34%	-0.1%
Diagnosed Substance Use Disorders - Any (Total)	3.94%	3.83%	-0.1%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Total - 30-Day Follow-Up	36.47%	36.84%	0.4%
Total - 7-Day Follow-Up	20.58%	22.65%	2.1%
Follow-Up After Emergency Department Visit for Substance Abuse (FUA)			
Total - 30-Day Follow-Up	27.83%	24.83%	-3.0%
Total - 7-Day Follow-Up	18.50%	16.44%	-2.1%
Pharmacotherapy for Opioid Use Disorder (POD)			
Total	32.96%	33.99%	1.0%

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	78.95%	79.09%	0.1%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	78.95%	75.10%	-3.9%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	58.33%	70.59%*	12.3%*
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	60.76%	63.68%	2.9%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood glucose testing - Total	56.22%	55.73%	-0.5%
Cholesterol Testing - Total	37.05%	35.22%	-1.8%
Blood glucose and Cholesterol Testing - Total	34.05%	32.88%	-1.2%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.44%	0.52%	0.1%
Appropriate Treatment for Children With URI (URI)			
Total	88.33%	87.74%	-0.6%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
Total	54.71%	52.63%	-2.1%
Use of Imaging Studies for Low Back Pain (LBP)	71.25%	68.60%	-2.7%
Use of Opioids at High Dosage (HDO)	3.95%	2.55%	-1.4%
Use of Opioids From Multiple Providers (UOP)			
Multiple Prescribers	19.74%	22.80%	3.1%
Multiple Pharmacies	2.06%	3.69%	1.6%
Multiple Prescribers and Multiple Pharmacies	1.48%	2.23%	0.8%
Risk of Continued Opioid Use (COU)			
Total - >=15 Days covered	3.03%	3.80%	0.8%
Total - >=31 Days covered	1.07%	2.65%	1.6%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Total	76.00%	80.26%	4.3%
Initiation and Engagement of AOD Dependence Treatment (IET)			
Initiation of AOD Treatment: Total	39.25%	39.33%	0.1%
Engagement of AOD Treatment: Total	10.63%	10.54%	-0.1%
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	89.19%	88.85%	-0.3%
Postpartum Care	76.01%	79.34%	3.3%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
Total	61.54%	59.39%	-2.2%

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	55.47%	57.86%	2.4%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	71.28%	74.04%	2.8%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	46.78%	50.48%	3.7%

Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator, * rate calculated based on denominator less than 30, **A lower rate for this measure indicates improvement.

One measure, Poor HbA1c Control, improved substantially by 10.5%.One measure, Persistence of Beta Blocker Treatment after a Heart Attack, showed a substantial decline of 10.8%.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the performance improvement projects (PIPs) was conducted in accordance with the protocol developed by CMS titled *EQR Protocol 1: Validating Performance Improvement Projects*. The protocol is used to validate components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

Select Health submitted two PIPs for validation. Topics included Diabetes Outcomes Measures and Well Care Visits for the Foster Care Population. Both PIPS received a score within the High Confidence in Reported Results range and met all the validation requirements. The tables that follow provide a summary of each PIP's status and the interventions underway.

Table 18: Diabetes Outcomes Measures PIP

Diabetes Outcomes Measures
The aim for the diabetes PIP is to lower HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and whose HbA1c levels are not <8%). The diabetes outcomes

Diabetes Outcomes Measures	
rates for measure year 2024 were not in the report, but a quarterly report as of April 2024 was submitted. The HEDIS audit reports showed improvement for HbA1c Control (<8%) from 42.09% in MY2022 to 50.12% in MY2023. Controlling High Blood Pressure at <140/90 mm/hg improved from 61.31% in MY2022 to 61.56% in MY2023.	
Previous Validation Score	Current Validation Score
84/85=99% High Confidence in Reported Results	100/100=100% High Confidence in Reported Results
Interventions	
• Data sharing by direct electronic medical record access • Year-round medical record review • Value based payment programs • Member incentives • Provider education • Newsletters	

Table 19: Well Care Visits for the Foster Care Population

Well Care Visits for the Foster Care Population	
The aim for the Well Care Visits for Children and Adolescents in Foster Care PIP is to increase compliance with well care visits for children and adolescents in foster care. For this PIP, there are several rates monitored. Several of these rates have been retired, thus the plan is tracking the current HEDIS measures only, including the Well-Child Visits in the First 30 Months of Life (W30) and the Child and Adolescent Well Care Visits (WCV). The W30 for first 15 months showed a 2023 rate of 53.96%, a slight decline from 54.93% in 2022. The W30 for 15-30 months showed 84.0%, a decline from the 2022 rate of 87.01%. The WCV rate for 3–11-year-olds was 76.82%, which is a slight improvement over the 2022 rate of 76.30%. For 12–17-year-olds, the WCV rate was 71.61%, a decline from the 2022 rate of 72.22%. For 18–21-year-olds, the WCV rate was 43.25%, a slight decline from the 2022 rate of 43.54%. The total WCV rate was 71.31%, down from 71.47% in 2022.	
Previous Validation Score	Current Validation Score
84/85=99% High Confidence in Reported Results	74/75 = 99% High Confidence in Reported Results
Interventions	
• Data sharing • Care management calls to new members • Monthly gaps in care reports • Clinical rounds • Weekly appointment reports • Provider education • A texting campaign • The Take Flight Program • Member incentives	

Table 20 lists the Recommendations that Constellation provided for the Well Care Visits for the Foster Care Population PIPs.

Table 20: PIP Recommendations

PIP	Section	Reason	Recommendation
Well Care Visits for the Foster Care Population	Was there any documented, quantitative improvement in processes or outcomes of care?	All well-child visit rates, with the exception of the 3–11-year-olds, declined from the previous rate. The W30 for first 15 months showed a 2023 rate of 53.96%, a slight decline from 54.93% in 2022. The W30 for 15-30 months showed 84.0%, a decline from the 2022 rate of 87.01%. The WCV rate for 3–11-year-olds was 76.82%, which is a slight improvement over the 2022 rate of 76.30%. For 12–17-year-olds, it was 71.61%, a decline from the 2022 rate of 72.22%. For 18–21-year-olds it was 43.25%, a slight decline from the 2022 rate of 43.54%. The total WCV rate was 71.31%, down from 71.47% in 2022.	Determine if additional barriers that have not been recognized are creating issues with the well care visits. Consider offering additional mobile, telehealth, or transportation services to meet the needs of the members.

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

Select Health continues to meet all the requirements in the Quality Improvement section for this EQR.

Figure 6: Quality Improvement Findings

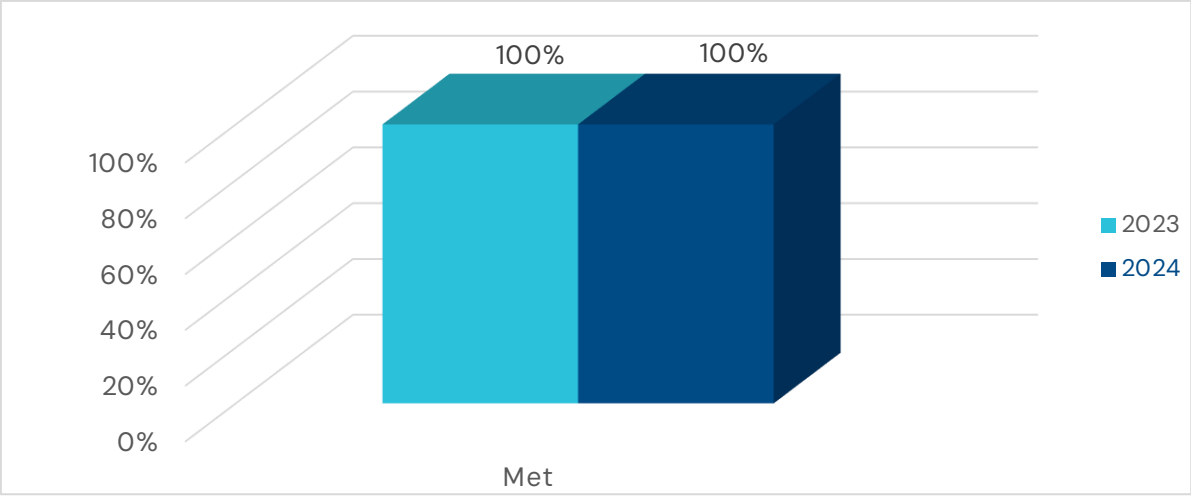


Table 21: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Select Health's QI Program Description includes the health plan's approach to health equity, data collection, monitoring, and quality improvement initiatives.	✓		
Provider performance monitoring and evaluation is included through mechanisms like PCP report cards, member-level data dashboards, and staff outreach.	✓		
The health plan was found to be compliant with the HEDIS technical specifications for rate calculations.	✓		
The performance improvement projects received a score in the High Confidence Range and met all the validation requirements.	✓		

Table 22: Quality Improvement Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Information regarding the QI Program was found on Select Health's website. However, the QI goals were outdated. The goals shared with providers were the 2023 goals and the goals shared with members were the 2022 goals.	*Recommendation: Update the goals for the Quality Management Program on the website.*	✓		
The Well Care Visits for the Foster Care Population PIP showed declines in the indicator rates.	*Recommendation: Determine if additional barriers that have not been recognized are creating issues with the well care visits. Consider offering additional mobile, telehealth, or transportation services to meet the needs of the members.*	✓		

IV. QUALITY IMPROVEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					Select Health's QI program is described in the Quality Management Program Description for 2024 by Select Health of South Carolina. This document highlights the commitment to providing high-quality healthcare services through initiatives like HEDIS performance measures, preventive programs, and population health management. The program focuses on member satisfaction, access to care, and improved health outcomes. The Program Description provides a comprehensive outline of the program's structure and lines of responsibility within the program. It details the roles and responsibilities of various committees, departments, and key positions involved in overseeing quality improvement activities, monitoring performance, conducting audits, and ensuring compliance with standards. The document also specifies the delegation of health plan functions to subcontractors, the reporting relationships, and the involvement of different stakeholders in ensuring the quality of care and services provided to members.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Information regarding the QI Program was found on Select Health's website. However, the QI goals were outdated. The goals shared with providers were the 2023 goals and the goals shared with members were the 2022 goals. *Recommendation: Update the goals for the Quality Management Program on the website.*
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					The QI Program Description includes investigation of trends noted through utilization data. This involves baseline utilization measurements, monitoring over-and underutilization, identifying disparities, assessing provider performance, and analyzing trends to improve healthcare delivery and outcomes. The QI Program utilizes data analytics, performance audits, and utilization management to ensure efficient and effective use of healthcare resources.
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, Select Health develops a QI Work Plan to guide the implementation, tracking, and reporting of QI activities. The 2023 and 2024 Work Plans were provided for this EQR. Both work plans encompassed various QI activities such as program documents; quality of clinical care; safety; quality of services; member experience; committee and department reports; and accreditation. The work plan tracks progress for each activity and is updated as needed.
IV B. Quality Improvement Committee						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QAPIC is a vital entity responsible for overseeing the QI Program. This committee plays a key role in developing, implementing, monitoring, and evaluating the program. The committee structure and responsibilities are outlined in the committee charter. Some of this committee's responsibilities include: • Assuring integration of QI activities throughout the health plan • Reviewing and suggesting new and/or improved QI activities • Monitoring and evaluating the utilization of health services and the effectiveness of the Utilization Management activities • Assessing the effectiveness of performance improvement projects through analysis and evaluation of results, initiating needed action, and following up as appropriate The Quality Clinical Care Committee and the Quality of Service Committee are subcommittees of the QAPIC. Both subcommittees provide direction and oversight of their respective areas of clinical and service QI activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QAPIC is chaired by the Market President. Membership includes leadership in various areas of the organization such as quality management, utilization management, provider services, member services, pharmacy, and behavioral health. Five external healthcare

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers and specialists are included as external voting members. The committee minutes provided demonstrated the committee met bi-monthly in 2023 and a quorum was established before starting the agenda.
3. The QI Committee meets at regular quarterly intervals.	X					The QAPIC meets bi-monthly or at a minimum of five times a year. A quorum is established upon attendance of at least 50 percent of voting members. Committee minutes are recorded at each meeting and reflect key discussion points, decisions made, rationale, planned actions, responsible person, and follow-up.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Committee minutes are recorded at each meeting and reflect key discussion points, decisions made, rationale, planned actions, responsible person, and follow-up.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					Constellation conducted a validation review of the HEDIS measures following the CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. Select Health uses Inovalon, a certified software organization, for calculation of HEDIS rates. Healthcare Data Company, LLC audited the rates. The performance measure validation found that Select Health was fully compliant with all HEDIS measures and met the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements per *42 CFR §438.330 (c) and §457.1240 (b).* One measure, Poor HbA1C Control, improved substantially by 10.5%. One measure, Persistence of Beta Blocker Treatment after a Heart Attack, showed a substantial decline of 10.8%.
IV 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					Select Health submitted two PIPs for validation. Topics included Diabetes Outcomes Measures and Well Care Visits for the Foster Care Population.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					Both PIPS received a score within the High Confidence in Reported Results range and met all the validation requirements. The Well Care Visits for the Foster Care Population PIP showed declines in the indicator rates. *Recommendation: Determine if additional barriers that have not been recognized are creating issues with the well-care visits. Consider offering additional mobile, telehealth, or transportation services to meet the needs of the members.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Select Health provides direct feedback to PCPs on their performance via a provider report card. The report card offers direct feedback on key quality measures compared to a peer group within the Select Health network. The report cards track progress and help identify areas for improvement. PCPs can access reports on their assigned members through the secure Provider Portal (NaviNet).
3. The MCO tracks provider compliance with						
3.1 Administering required immunizations;	X					
3.2 Performing EPSDTs/Well Child Visits.	X					Policy QI 154.006, EPSDT, and QI 154.014, Monitoring Foster Care Membership Utilization and Compliance with Well Care Visits, describes how Select Health tracks member and provider compliance with EPSDT services. This includes notification of members and providers about age-appropriate and relevant preventive health screenings and services, as well as tracking when members did not receive recommended assessments and/or treatments. Member and Provider Incentive Programs are offered by Select Health to encourage and reward members and providers for engaging in specific health-related activities and behaviors.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Select Health conducts an annual evaluation of the QI Program which involves various aspects such as clinical performance, quality studies, and activities. The evaluation includes assessing effectiveness, identifying areas for improvement, and proposing goals for the following year. This evaluation is initiated by the Quality Department and submitted to the QAPIC for review and approval. The Quality Management Program Evaluation of Calendar Year 2022 was submitted. Select Health indicated they were in the process of completing the 2023 QI Program Evaluation. The health plan anticipated this evaluation would be completed and submitted to the QAPIC for review and approval on August 24, 2024.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

E. Utilization Management

42 CFR § 438.210(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)

Select Health's Utilization Management (UM) Program Description and various policies outline the health plan's program structure, scope, and objectives for physical health and behavioral health services. Also, PerformRx's Program Description and several policies provide a descriptive overview of the health plan's pharmacy program. However, there is currently no verbiage that outlines the specialty pharmacy process.

Select Health's Medical Director provides overall oversight of the UM Program. Responsibilities include policy development, conducting second level reviews, consultations, and provider education. The Behavioral Health Director provides oversight over all aspects of the behavioral health program, which entails committee participation, policy development, and adverse benefit decision reviews. The Pharmacy Director provides clinical oversight of the pharmacy program.

Select Health recently updated their policy referencing the Preferred Provider Program to a corporate policy. During onsite discussion, the health plan mentioned that the UM Department and the Provider Network Management Director were in the final stages of developing this program.

Coverage and Authorization of Services

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

Initial review of a request for service authorization is conducted by Select Health's licensed clinical staff using clinical criteria such as InterQual, American Society of Addiction Medicine, the South Carolina Provider Manual, etc. Standard authorization requests are processed within 14 calendar days and urgent requests are processed within 72 hours. Pharmacy requests are processed within 24 hours. Constellation's review of a sample of approval files reflected that the clinical determinations were made by appropriate clinical staff and completed timely. The review of sample of denial files reflected that second level reviews were completed by an appropriate physician, completed timely, and the reasoning for the adverse benefit decision was clearly explained to the member.

For quality assurance, Select Health conducts Inter-Rater-Reliability testing and clinical audits for physicians and non-physicians to ensure consistency in clinical criteria application.

Appeals

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

Processes for handling standard and expedited written and verbal appeal requests are described in Policy MMS.100, Member Grievances and Appeals Process, the Utilization Management Program Description, the Member Handbook, the Provider Manual, and on Select Health's website. The

Member Handbook (page 28) and the Provider Manual (pages 14, 42, and 43) specify that appeal resolution notifications are mailed to the member via certified mail with return receipt requested. Policy MMS.100, Member Grievances and Appeals Process, states on page eight, "the notice of denial will be sent by certified mail, return receipt requested." It was noted in the Review/Revision Dates section of this policy (pages 19 and 20) that the policy was revised and references to the certified mail requirement were removed in the "process" section of the policy. Select Health indicated onsite that this was no longer a contract requirement. SCDHHS confirmed the contract and the *SCDHHS MCO Policy and Procedure Guide* require that the appeal resolution notification be sent to the member via certified mail with return receipt requested.

All appeal files reviewed for this EQR were resolved in a timely manner and were reviewed by appropriately credentialed reviewers. However, none of the appeal resolution notifications included evidence that the notice had been sent to the member via certified mail as required by the *SCDHHS Contract, Section 9.1.6.3.1.1.* and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 9*. This was discussed during the onsite and Select Health indicated the notices are not sent via certified mail despite the policy, the Provider Manual, and the Member Handbook indicating the notices are sent via certified mail.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

Select Health's scope, objectives, and guidelines for the health plan's care management program, foster care management program, and transition of care services are outlined in the Population Health Management Program Description and several policies.

Members are referred to care management services through various resources such as medical and behavioral health claims, pharmacy claims, laboratory results, provider referrals, health plan activity, and member/caregiver requests. Once an initial assessment has been completed, members are stratified to the appropriate risk level and are provided care management services based upon their identified needs. Specialized programs and services such as an appointment tracking system and First Choice Fit: Taking Flight are offered for children in foster care.

Select Health also offers Targeted Care Management (TCM) services for special populations. During onsite discussion, Select Health described that TCM services are also offered for adults in need of protective services. However, these services were not included in the program description or in policy.

Select Health measures member experience with select programs through Member Experience surveys and via processing any member complaints.

Constellation's review of the sample care management files indicated that the appropriate care management activities were provided to members based upon their assigned risk level.

Select Health met 98% of the standards in the UM section. The process for handling appeals received a "Not Met" score.

Figure 7: Utilization Management Findings

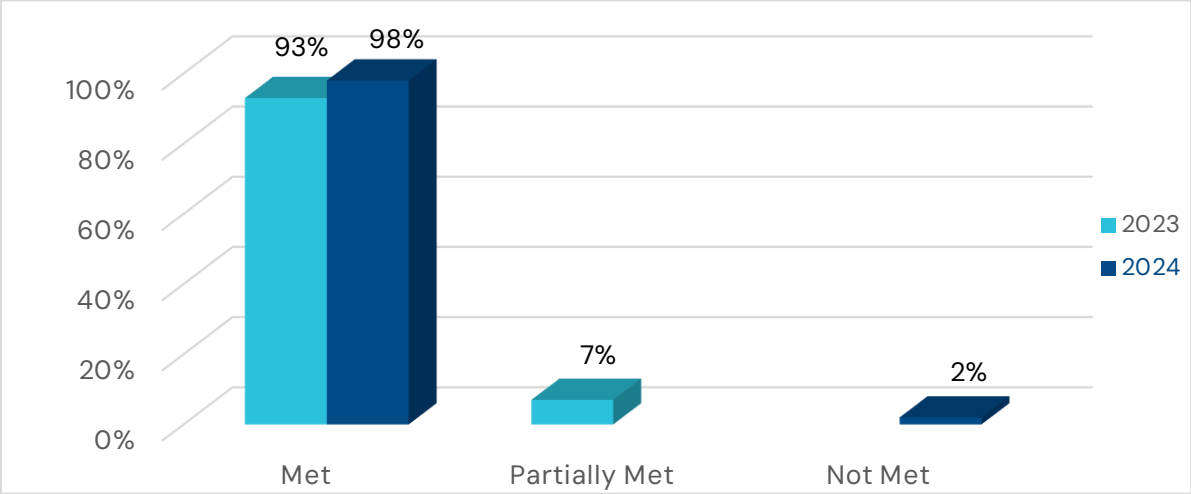


Table 23: Utilization Management Comparative Data

Section	Standard	2023 Review	2024 Review
The Utilization Management (UM) Program	The mechanism to provide for a preferred provider program.	Partially Met	Met
Medical Necessity Determinations	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Partially Met	Met
Appeals	The MCO applies the appeal policies and procedures as formulated.	Partially Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 24: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Select Health maintained a 100% target goal of timeliness for processing Psychiatric Residential Treatment Facility (PRTF) authorizations.		✓	

Strengths	Quality	Timeliness	Access to Care
Select Health has a tracking system to report any provider appointments scheduled for children currently in foster care and receiving care management services. This allows the South Carolina Department of Social Services nurses to update members' records and ensure there are no gaps in care, including immunization visits.	✓		✓
First Choice Fit: Taking Flight is designed for members aging out of the foster care system, which aims to teach life skills.	✓		
All appeal files reviewed for this EQR period were resolved timely and were reviewed by appropriately credentialed reviewers.		✓	✓

Table 25: Utilization Management Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Select Health recently updated their policy referencing the Preferred Provider Program to corporate Policy UM.003 Standard and Expedited Prior Authorizations. During onsite discussion, the health plan mentioned that the UM Department and the Provider Network Management Director are in the final stages of developing the Preferred Provider Program.	*Recommendation: Complete finalization of a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy UM.03 Standard and Expedited Prior Authorization.*	✓		
There is currently no verbiage within Select Health's policy and Program Descriptions that outlines the specialty pharmacy process. During an onsite discussion, Select Health described that specialty medications require prior authorization and that members can obtain these medications from a pharmacy contracted through the health plan. Select Health also stated that this process was outlined in the Program Description or a policy; however, Constellation was unable to locate the specialty pharmacy process in either the policy or the Program Description.	*Recommendation: Ensure that your Specialty Pharmacy process is clearly outlined within your policy or Program Description in accordance with the SCDHHS Contract, Section 4.2.21.*	✓		
Policy MMS.100, Member Grievances and Appeals Process, and the UM Program Description do not describe processes ensuring that appeal resolution notices are sent to members via certified mail.	*Recommendation: Revise the process section of Policy MMS.100, Member Grievances and Appeals Process, and include the requirement and the process for sending the appeal*			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
The Member Handbook (page 28) and Provider Manual (pages 14, 42, and 43) indicate that appeal resolution notices are sent to members via certified mail with return receipt requested.	*resolution notifications to the member via certified mail with return receipt requested as required by the SCDHHS Contract, Section 9.1.6.3.1.1 and the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 9.*			
For the sample of appeal files reviewed for the 2024 EQR, none of the appeal decision letters included evidence that the appeal resolution notice had been mailed certified with return receipt requested as required by the *SCDHHS Contract, Section 9.1.6.3.1.1.* During the onsite, Select Health indicated the appeal resolution notices were not being sent to members via certified mail.	*Quality Improvement Plan: To comply with contractual requirements, ensure appeal resolution notices are sent via certified mail.*	✓		✓
Targeted Care Management services for adults in need of protective services were not included in a program description or in a policy.	*Recommendation: Include verbiage in a policy or Program Description to explicitly state that Targeted Case Management services are available for adults in need of protective services, in accordance with the SCDHHS Contract, Section 4.2.26.*	✓		

V. UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V. A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Select Health's Utilization Management Program Description and various policies outline the health plan's program structure, scope, and objectives for physical health and behavioral health services. Also, PerformRx's Program Description provides a descriptive overview of the health plan's pharmacy program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					The Medical Director's roles and responsibilities entail policy development, conducting second level reviews, consultations, and provider education. The Behavioral Health Director provides oversight over all aspects of the behavioral health program, which entails committee participation, policy development, and adverse benefit decision reviews. The Pharmacy Director provides clinical oversight of the pharmacy program.
1.3 guidelines / standards to be used in making utilization management decisions;	X					As outlined in various policies and the UM Program Description, standard authorization requests are processed within 14 calendar days and urgent requests are processed within 72 hours. Pharmacy requests are processed within 24 hours. Clinical reviewers use clinical criteria such as InterQual, American Society of Addiction Medicine, South

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Carolina Provider Manual, etc. in conducting clinical determinations as outlined in the health plan's UM Program Description and Policy UM.088S Utilization Management Clinical Criteria.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					Policy UM.016 Assessment of New and Emerging Medical Treatments and Technology, indicates the Clinical Policy Department is comprised of Medical Directors and Behavioral Health Care Professionals who are responsible for conducting formal reviews of new treatments and technologies.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					The UM Program Description states professional staff do not receive incentives directly or indirectly for making clinical determinations and that all staff are required to adhere to the health plan's Code of Conduct that is communicated at hire and yearly to all staff.
1.7 the mechanism to provide for a preferred provider program.	X					Select Health recently updated their policy referencing the Preferred Provider Program to corporate Policy UM.003, Standard and Expedited Prior Authorizations. During onsite discussion, the health plan mentioned that the UM Department and the Provider Network Management Director are in the final stages of developing the Preferred Provider Program. They indicated that there are currently two providers who might be eligible for participation. *Recommendation: Complete finalization of a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy UM.03 Standard and Expedited Prior Authorization.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V. 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 used are in place for determining medical necessity for all covered benefit situations.	X					Initial review of a request for services is conducted by clinical staff using clinical criteria such as InterQual, American Society of Addiction Medicine, South Carolina Provider Manual, etc. The UM Medical/Behavioral Health Director may utilize information from a board-certified consultant familiar with the specialty, published scientific evidence, and information from an appropriate government regulatory body, etc. in conducting medical necessity reviews if the service is not included in the criteria as outlined in the health plan's UM Program Description and Policy UM.088S Utilization Management Clinical Criteria.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation's review of the sample approval files reflected that the UM reviewers utilized clinical criteria consistency in conducting clinical determinations.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					As outlined in Policy UM.708, Inter Rater Reliability (IRR), and in the UM Program Description, Select Health conducts IRR testing and clinical audits for physicians and non-physicians to ensure consistency in clinical criteria application and quality assurance. The projected benchmark is 90% and refresher training is provided if an individual scores below the target goal. Based upon the target goal, the IRR quarterly scores were above 94%, with the exception of appeals, which scored 86%. After retraining, the UM reviewers received a passing score.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Select Health's pharmacy program is outlined in Policy 154.400, Pharmacy Benefits, Policy 150.402, Beneficiary Lock-In Program, the Quality Management Program Description, and in the PerformRx Program Description. The Comprehensive Drug List has been managed by SCDHHS since 7/1/24 and the health plans are currently in a six-month grace period before implementing the changes of the drug list. During onsite discussion, Select Health described that they receive notification of the changes via email and any negative formulary changes are communicated to the member.

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					Policy MED (PA) 150.400, Pharmacy Benefits, describes that Select Health provides a 72-hour supply of medication to members in emergent situations while awaiting a Prior Authorization decision. However, there is currently no verbiage that outlines the specialty pharmacy process. During onsite discussion, Select Health described that specialty medications require prior authorization and that members can obtain these medications from a pharmacy contracted through the health plan. Select Health also stated that this process was outlined in the Program Description or a policy; however, Constellation was unable to locate the specialty pharmacy process in either the policy or the Program Description. *Recommendation: Ensure that the Specialty Pharmacy process is clearly outlined within the policy or Program Description in accordance with the SCDHHS Contract, Section 4.2.21.*
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Emergency and post-stabilization services are provided at no cost to members as outlined in the Member Handbook, Provider Manual, Policy UM.003, Standard and Expedited Prior Authorization of Services, and Policy UM.905, Emergency Room Services.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Review of a sample of approval files reflected that clinical determinations were made by appropriate clinical reviewers.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the approval files reflected that the approval decisions were completed timely. Also, Select Health maintained its 100% target goal for timeliness for processing PRTF authorizations.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					The review of a sample of denial files reflected that additional clinical information was requested appropriately prior to making an adverse benefit determination.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of a sample of denial files reflected that the adverse benefit decisions were reviewed by an appropriate physician prior to the denial.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					
V. C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Appeal terminology is appropriately defined in the Member Handbook, Provider Manual, and in Policy MMS.100, Member Grievances and Appeals Process.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing an appeal;	X					Processes for filing written or verbal appeals are outlined in Policy MMS.100, Member Grievances and Appeals Process, and the UM Program Description and were discussed onsite.
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					The 72-hour resolution timeframe for appeals where the member's health conditions may require expedited resolution is clearly indicated in Policy MMS.100, Member Grievances and Appeals Process, the UM Program Description, the Member Handbook, Provider Manual, and on the website.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					The Member Handbook (page 28) and the Provider Manual (pages 14, 42, and 43) specify that appeal resolution notifications are mailed to members via certified mail with return receipt requested. Policy MMS.100, Member Grievances and Appeals Process, states on page eight, "the notice of denial will be sent by certified mail, return receipt requested." It was noted in the Review/Revision Dates section of this policy (pages 19 and 20) the policy was revised and references to the certified mail requirement were removed in the process section of the policy. Select Health indicated onsite that this was no longer a contract requirement. SCDHHS confirmed the contract and the *SCDHHS MCO Policy and*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Procedure Guide require that the appeal resolution notification be sent to the member via certified mail with return receipt requested. *Recommendation: Revise the process section of Policy MMS.100, Member Grievances and Appeals Process, and include the requirement and the process for sending the appeal resolution notifications to the member via certified mail with return receipt requested as required by the SCDHHS Contract, Section 9.1.6.3.1.1 and the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 9.*
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.			X			All appeal files reviewed for this EQR were resolved in a timely manner and were reviewed by the appropriately credentialed reviewer. However, none of the appeal resolution notifications included evidence that the notice had been sent to the member via certified mail as required by the *SCDHHS Contract, Section 9.1.6.3.1.1.* and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 9*. This was discussed during the onsite and Select Health indicated the notices are not sent via certified mail despite the policy, the Provider Manual, and the Member Handbook indicating the notices are sent via certified mail. *Quality Improvement Plan: To comply with contractual requirements, ensure appeal resolution notices are sent via certified mail.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					Select Health's scope, objectives, and guidelines for the health plan's care management program are outlined in the Population Health Management Program Description and Policy PH-CC 301S, MCO Transition Coordinator. Additionally, an overview of Select Health's Foster Care Management Program is outlined in the Population Health Management Program Description and Policy PH-CC 303S, Foster Care Rounds, Interagency Meetings, and Child and Family Team Meetings. During onsite discussion, Select Health shared that they are currently undergoing a program reorganization process due to SCDHHS contractual regulation changes to ensure that care management activities fully address the needs of several member subpopulations.
2. The MCO has processes to identify members who may benefit from care management.	X					As described in the Population Health Management Program Description, members are referred to care management services through various resources such as medical and behavioral health claims, pharmacy claims, laboratory results, provider referrals, health plan activity, and member/caregiver requests. Regarding children in foster care, the members are assigned to care coordination or

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Complex Care Management for 3 months to a year depending on various risk levels and needs such as emergency room visits, hospital admissions, planned admissions, use of medical equipment, etc.
3. The MCO provides care management activities based on the member's risk stratification.	X					The Population Health Management Program Description describes that once members are stratified to the appropriate risk level, care management activities are provided based on the assigned level. The levels include : • Keeping Member/Participants Healthy- Wellness, Prevention, Early Intervention (Low Risk) for members who are mostly healthy and who will receive reminders for wellness visits, preventive wellness services, and health education; • Managing Emerging Risks-Condition and Diagnosis Management (Moderate Risk) assigned for members to receive short term needs to a chronic condition and may also include pregnant members, Foster Care Members, and other members who may benefit from disease management programs; and • Management of Multiple Chronic Illness and/or Disabilities (High Risk) for members who require complex care management support. Additionally, specialized programs such as Neonatal Intensive Care Unit Care Management, Bright Start Maternity Program, and Asthma care are offered to members with specialized needs.
Of 4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					As outlined in various policies, the website, and the Member Handbook, Select Health provides coordinated care management services to ensure members receive the most appropriate level of care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Once an assessment is completed and a treatment plan is developed, care management activities such as appointment scheduling, referrals to community resources, and an ongoing assessment of needs are provided to members. Additionally, foster care management services are offered to children in the foster care system. The care management team has created a tracking system to report any provider appointments scheduled for these members. This allows the South Carolina Department of Social Services nurses to update members' records and ensure that there are no gaps in care, including immunization visits. There is also a specialized program, First Choice Fit: Taking Flight, designed for members aging out of the foster care system, which aims to teach life skills. Additional TCM services are provided for members who are chronically mentally ill, diagnosed with an intellectual disability, or children diagnosed with sickle cell disease. During onsite discussion, Select Health described that TCM services are also offered for adults in need of protective services; however, Constellation was unable to find verbiage confirming this in accordance with the contractual requirements. *Recommendation: Include verbiage in a policy or Program Description to explicitly state that Targeted Case Management services are available for adults in need of protective services, in accordance with the SCDHHS Contract, Section 4.2.26.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					As outlined in the Population Health Management Program Description, Select Health provides Integrated Medical-Behavioral Health Management to aid in promoting whole person wellness and to provide integrated interventions to address any behavioral health and presenting medical needs for members.
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					
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					Select Health conducts Member Experience surveys that assess members' satisfaction with services that are conducted for members receiving Complex Care Management and Bright Start Services. Member complaints are also analyzed in conjunction with the experience feedback and the results are discussed during the Quality Assessment Performance Improvement Committee meeting for feedback.
8. Care management and coordination activities are conducted as required.	X					Constellation's review of a sample of care management files indicated that care management activities were conducted as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources.
V. E. Evaluation of Over/ Underutilization						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

F. Delegation

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

For this EQR, Select Health has delegation agreements with 16 entities as shown in *Table 26: Delegated Entities and Services*. Each delegation agreement specifies the activities the delegate will perform on behalf of the health plan. The agreements include provisions for oversight monitoring.

Table 26: Delegated Entities and Services

Delegated Entities	Delegated Services
• Evolent Health (formerly National Imaging Associates)	Non-Emergent Advanced Imaging Utilization Management
• BHM Health Solutions	Behavioral Health Decision Reviews on Cases as Assigned
• PerformRx	Pharmacy Benefit Management
• Infomedia Group, Inc. d/b/a Carenet Healthcare Solutions	24/7 Nurse Triage Line
• AnMed Health • AU Medical Center • Health Network Solutions (HNS) • Lexington Health, Inc. • Medical University of South Carolina (MUSC) • Prisma Health • PSG Delegated Services • Regional Health Plus (RHP) • Roper St. Francis (RSF) • Self Regional Healthcare • St. Francis Physician Services (SFPS) • Tenet Physician Resources, LLC	Credentialing/Recredentialing

Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, outlines Select Health's policy and procedures for delegation of credentialing and recredentialing activities. Policy 277.010, Oversight of Subcontractor-Delegates, outlines the policy and procedures for oversight of non-credentialing delegates. Both policies cover responsibilities, contract implementation procedures, monitoring processes, and corrective action plans. For any new delegate, Select Health requires the delegate to pass a pre-delegation audit prior to performing any activities. An annual audit is conducted for each delegate that includes a comprehensive review of the delegate's processes and a file review, where applicable, to ensure compliance with Select Health's established thresholds and criteria. If a delegate does not pass the pre-delegation assessment or the annual assessment, Select Health may terminate parts or all of the

delegation agreement. The delegation agreement and policy do not allow any delegate to sub-delegate any activities without written approval.

Select Health provided documentation of the annual oversight audits conducted for all non-credentialing and credentialing delegates. Results of the credentialing delegate audits are presented to the Credentialing Committee, and the non-credentialing monitoring results are presented to the Quality of Service Committee. There were no issues identified with the monitoring.

Figure 8: Delegation Findings provides an overview of the scores received in the Delegation section of the 2024 EQR compared to the 2023 EQR results.

Figure 8: Delegation Findings

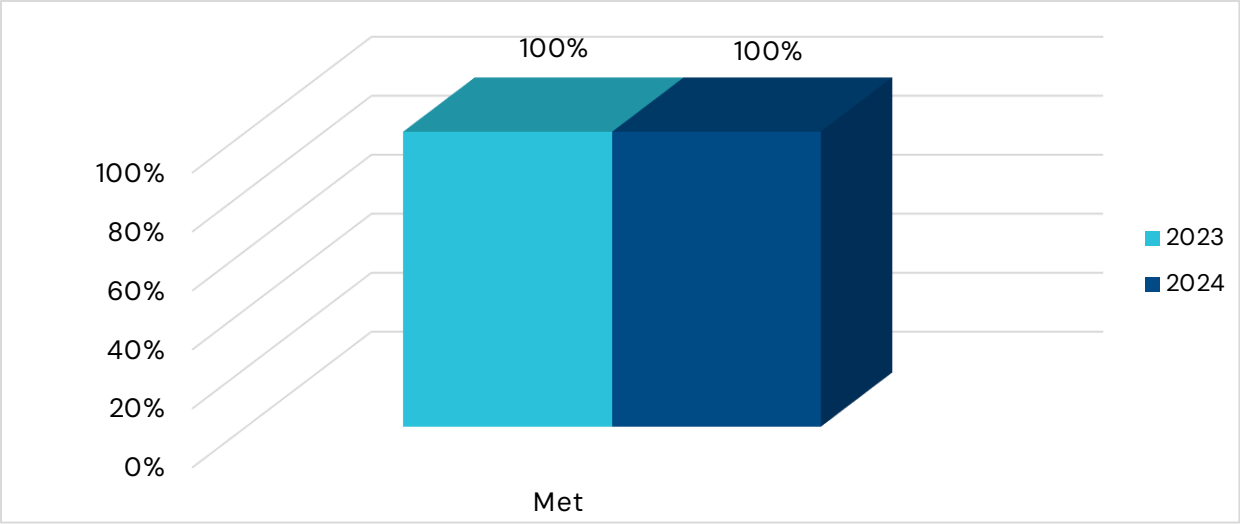


Table 27: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
A Delegation Agreement is mutually agreed upon and executed, outlining the delegated functions, audit processes, and corrective actions if needed, providing a clear framework for the delegation process.	✓		
Select Health has a uniform process for contracting with, managing the performance of, and terminating subcontractors to whom activities have been delegated.	✓		
Oversight and monitoring the Delegate's compliance with requirements is conducted at regular intervals.	✓	✓	

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, outlines Select Health's policy and procedures for delegation of credentialing and recredentialing activities. Policy 277.010, Oversight of Subcontractor-Delegates, outlines the policy and procedures for oversight of non-credentialing delegates. Both policies cover responsibilities, contract implementation procedures, monitoring processes, and corrective action plans. For any new delegate, Select Health requires the delegate to pass a pre-delegation audit prior to performing any activities. An annual audit is conducted for each delegate that includes a comprehensive review of the delegate's processes and a file review, where applicable, to ensure compliance with Select Health's established thresholds and criteria. If a delegate does not pass the pre-delegation assessment or the annual assessment, Select Health may terminate parts or all of the delegation agreement. The delegation agreement and policy do not allow any delegate to sub-delegate any activities without written approval.
2. 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					For this EQR, Select Health has delegation agreements with 16 entities. Each delegation agreement specifies the activities the delegate will perform on behalf of the health plan. The agreements include provisions for oversight monitoring.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. 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					Select Health provided documentation of oversight audits conducted for all non-credentialing and credentialing delegates. There were no issues identified with the monitoring.

G. Mental Health Parity

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

Mental Health Parity Non-Quantitative Treatment Limitations Assessment

NQTLs are assessed for both comparability of standards/processes, and the stringency with which they are applied. Constellation reviewed the following materials to complete the Parity Evaluation for 2024:

- Program Descriptions and Evaluations
- Reports (Utilization, Denials, Appeals, Network Access)
- Satisfaction Surveys
- Parity tools submitted by Select Health

Comparability:

Clinical reviews are completed using nationally recognized criteria for medical/surgical, mental health, and substance use disorder determinations. No internally developed criteria are used. Select Health's model of care includes integrated behavioral health/substance use disorder services, with appropriately licensed staff performing initial reviews, and Behavioral Health Medical Directors reviewing any requests that do not meet clinical standards for approval.

Constellation notes there were 86 quality of care concerns for mental health/substance use disorder (MH/SUD) and 84 for medical/surgical. Since there are far fewer interactions with the MH/SUD health care delivery system than medical/surgical, a lower number of complaints would be expected. Select Health notes, in their analysis, that 40% of the MH cases have been referred for issues related to care coordination. Select Health has implemented interventions to address this, both internally within the Case Management department and with provider documentation requirements.

Select Health met the out of network (OON) utilization goals for both medical/surgical and MH/SUD, although OON requests for MH/SUD services were more than triple those of medical/surgical requests. Select Health confirmed their policy of extending a contract offer to any willing provider who meets credentialing requirements. There was positive movement in accessibility of services for both MH Prescribers and Non-Prescribers from the 2022 measurement year.

Stringency:

To examine stringency, denial, appeal, and appeal overturn rates are examined. Select Health's denial rate for medical/surgical and MH/SUD do not demonstrate any issues with stringency. Constellation did find higher appeal overturn rates in the MH/SUD population once an appeal was filed, especially with outpatient services. It could be worthwhile to separate MH requests from SUD requests for the next review cycle, as opioid abatement programs will soon be available, and there is potential for abusive provider practices in treating persons with substance use disorder(s).

Mental Health Parity Quantitative Treatment Limitations Assessment

Two templates were provided to Select Health to complete for the Mental Health Parity Assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There are two steps required to conduct this review. For step one, Constellation determined if a particular type of financial requirement or QTL applied to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, Constellation determined the predominant value for financial or treatment limitations by identifying the value that applied to more than half of medical/surgical benefits within that classification. *Table 28: Mental Health Parity Quantitative Treatment Limitations Assessment Steps* provides an overview of the results.

Table 28: Mental Health Parity Quantitative Treatment Limitations Assessment Steps

Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
Inpatient	Y	Copay $25.00	Accepted
Outpatient	Y	Copay $3.30	Accepted
Pharmacy	Y	Copay $3.40	Accepted

Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
Emergency Services	N/A	N/A	N/A

Note. Note. Out of Network services are not covered, and thus, were not examined. There is no copay or session limit for Emergency Services.

The assessment of mental health parity conducted for Select Health found the health plan continues to meet all the requirements for mental health parity as demonstrated in *Figure 9: Mental Health Parity Findings*.

Figure 9: Mental Health Parity Findings

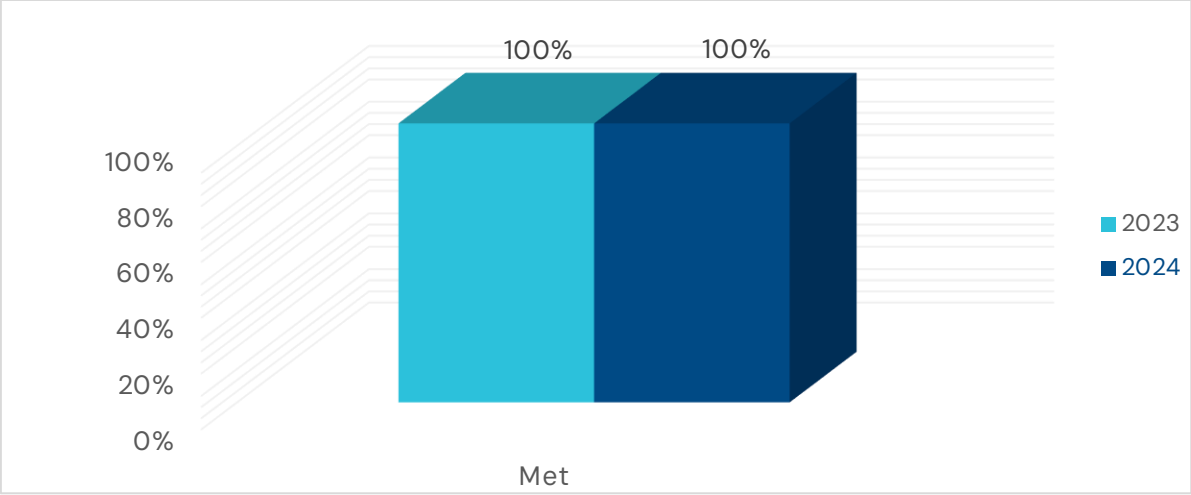


Table 29: Mental Health Parity Strengths

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

VII. MENTAL HEALTH PARITY

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. MENTAL HEATLH PARITY						
1. The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations.	X					
2. The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	X					Two templates were provided to Select Health to complete for the Mental Health Parity Assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There are two steps required to conduct this review. For step one, Constellation determined if a particular type of financial requirement or QTL applied to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, Constellation determined the predominant value for financial or treatment limitations by identifying the value that applied to more than half of medical/surgical benefits within that classification.

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Assessment of Quality Improvement Plans from Previous EQR

Attachment 1: Initial Notice and Materials Requested for Desk Review

July 8, 2024

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

Dear Ms. Thompson:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2024 External Quality Review (EQR) of Select Health of South Carolina is being initiated. An external quality review (EQR) conducted by Constellation Quality Health, formally The Carolinas Center for Medical Excellence, is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by Constellation Quality Health to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review, onsite visit and will address all contractually required services as well as follow-up of any areas of weakness identified during the previous review. The Constellation Quality Health EQR team plans to conduct the virtual onsite on August 21st and August 22nd. In preparation for the desk review, the items on the enclosed desk materials list should be provided to Constellation Quality Health no later than July 22, 2024.

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

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Project Manager, External Quality Review

cc: SCDHHS

External Quality Review 2024

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base. Please include all of the following:
    a. A list of all contracted status 1 and status 2 Providers. This list should be submitted as an excel spreadsheet and include county, specialty, provider identified limitations (open or closed panel), and a description for any codes used in the spreadsheet.
    b. Geographic access assessments
    c. Network development plans
    d. Enrollee demographic studies
    e. Population needs assessments
    f. Calculation of provider-to-enrollee ratios (PCP and specialist)
    g. Analysis of in-network and out-of-network utilization data

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

Excel Spreadsheet Format

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

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

7. A completed Provider Network File Questionnaire.

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

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

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

11. The Quality Improvement work plans for 2023 and 2024.

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

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

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

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

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

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

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

19. A complete list of all members enrolled in the case management program from August 2023 through June 2024. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

20. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for August 2023 through June 2024. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of August 2023 through June 2024.

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

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

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

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

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

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

30. A copy of the providers' handbook or manual.

31. A sample provider contract.

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

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

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

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

35. Results of the most recent annual evaluation (include completed tools) and ongoing monitoring activities for all delegated entities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.

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

37. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of August 2023 through June 2024. Include any medical information and physician review documentation used in making the denial determination.

d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of August 2023 through June 2024, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

38. Copies of the following documents needed to complete the Mental Healthy Parity Assessment.
    - Program Descriptions:
        i. Utilization Management
        ii. Mental Health/Substance Use Disorder (MH/SUD)
        iii. Medical/Surgical (MS)
        iv. Quality
    - Reports:
        i. M/S Denial - denial rates, administrative and clinical (IP, OP, ER, RX)
        ii. M/S Appeal – overturn rates (IP, OP, ER, RX)
        iii. M/S Pharmacy Denials - -denial rates, administrative and clinical (IP, OP, ER, RX)
        iv. M/S Pharmacy Appeals - -overturn rates (IP, OP, ER, RX)
        v. MH/SUD Denials- denial rates, administrative and clinical (IP, OP, ER, RX)
        vi. MH/SUD Appeals - overturn rates (IP, OP, ER, RX)
    - Authorization Report
        i. Out of Network Utilization (M/S)
        ii. Out of Network Utilization (MH/SUD)
        iii. Network Access Reports (M/S)
        iv. Network Access reports (MH/SUD)
    - Parity Tools
        i. Benefit Map (Appendix B)
        ii. NQTL List (Appendix C)
        iii. NQTL Comparison Chart (Appendix D)
        iv. QTL List (Appendix E)
        v. QTL Tool (Excel Spreadsheets)

These materials:

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

Attachment 2: Materials Requested for Onsite Review

Select Health of SC

External Quality Review 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. A copy of the packet sent to the QAPI Committee members for the meeting held in June 2024. The file we received could not be opened.
3. A copy of the QAPI Committee meeting minutes for meetings held in April and June of 2024.
4. A copy of the staff training materials used for grievance and appeal training. This was noted on the staff training agenda, but we did not receive the materials used for this training.
5. A copy of the Standard Operating Procedures or desk procedures for managing hysterectomies, abortions, and sterilizations.
6. The Mental Health Parity Assessment Utilization Reports with the rates calculated as per thousand.
7. A copy of any internally developed (medical necessity and continued stay) criteria used for Mental Health and Substance Use Disorder (SUD). Also, the policy and procedure for the development and approval of the criteria.

Materials should be uploaded to the secure Constellation Quality Health EQR File Transfer site at: https://egro.thecarolinascenter.org

Attachment 3: EQR Validation Worksheets

EQR PIP Validation Worksheet

Plan Name:	Select Health
Name of PIP:	Comprehensive Diabetes Care
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee care needs.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	HEDIS Hybrid methodology was utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	MET	HEDIS Hybrid methodology was utilized.
4.3 Did the sample contain a sufficient number of enrollees? (5)	MET	HEDIS Hybrid methodology was utilized.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measures are HbA1C<8 and BP control <140/90.

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The rates for the two outcomes based on the HEDIS audit reports showed improvement for <8% from 42.09% in MY2022 to 50.12% in MY2023. The controlling high blood pressure at <140/90 mm/hg showed improvement from 61.31% in My 2022 to 61.56% in MY 2023.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	The improvement in indicators appears to be related to interventions implemented including data sharing by EMR access, year-round Medical Record Review, value based payments, member incentives, and provider education.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	100
Project Possible Score	100
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Select Health
Name of PIP:	Well-Care Visits for Foster Care Members
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of enrollee care needs.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Full eligible population was utilized based on designation of Aid Category FG3.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Not applicable.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Not applicable.
Step 5: Review Selected PIP Variables and Performance Measures		

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	All well-child visit rates, with the exception of the 3-11 year olds declined from the previous rate. The W30 for first 15 months showed a 2023 rate of 53.96%, a slight decline from 54.93% in 2022. The W30 for 15-30 months showed 84.0%, a decline from the 2022 rate of 87.01%. WCV rates for 3-11 year olds was 76.82%, which is a slight improvement over the 2022 rate of 76.30%; for 12-17 year olds it was 71.61%, a decline from the 2022 rate of 72.22%, and for 18 to 21 year olds it was 43.25%, a slight decline from the 2022 rate of 43.54%. The total WCV rate was 71.31%, down from 71.47% in 2022. Recommendation: *Determine if additional barriers that have not been recognized are creating issues with well-care visits; Consider offering additional mobile, telehealth, or transportation services to meet the needs of the members.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	No improvement was identified.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included in the most recent approved PIP report.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	74
Project Possible Score	75
Project Rating Score	99%

Audit Designation
High Confidence in Reported Results

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

EQR Performance Measure Validation Worksheet

Plan Name:	Select Health
Name of PM:	All HEDIS Measures
Reporting Year:	2024
Review Performed:	2024

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2023 Volume 2 Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Denominator sources were accurate.
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of rates adhered to numerator specifications.
N3 Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	MET	Documentation and tools were found to be compliant.
N4 Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	MET	Integration methods were found to be compliant.
N5 Numerator - Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	MET	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1 Reporting	Were the state specifications for reporting performance measures followed?	MET	HEDIS specifications were followed and found compliant.

Overall Assessment	Plan uses NCQA certified software vendor, Inovalon. Audit report noted compliance for HEDIS measures.

VALIDATION SUMMARY

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

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

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

Audit Designation
Fully Compliant

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

EQR Network Adequacy Validation Worksheet

Plan Name:	Select Health
Reporting Year:	2023
Review Performed:	2024

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

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
2.1 Are the methods selected by the MCO appropriate for the state? (10)	MET	Methods aligned with State standards.
2.2 Are the methods selected by the MCO appropriate to the state Medicaid and CHIP population(s)? (10)	MET	Methods aligned with populations.
2.3 Are the methods selected by the MCO adequate to generate the data needed to calculate the indicators according to the State's expectations? (10)	MET	Methods generated required data for NA assessment.
2.4 Does the MCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? (1)	MET	Provider network file questionnaire indicated

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

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

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

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

Points Earned	99
Possible Score	99
Validation Findings	100%

Audit Designation
High Confidence in Reported Results

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

EQR Survey Validation Worksheet

Plan Name	Select Health
Survey Validated	CAHPS MEMBER SATISFACTION – ADULT
Validation Period	2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	The survey has been tested for validity. *Documentation:* Press Ganey Adult CAHPS Report MY2023
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	The survey has been tested for reliability. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Adult CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult CAHPS Report MY2023
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Adult CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Adult CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 12.5%, which is a decline from the previous year's rate. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult CAHPS Report MY2023

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Adult CAHPS Report MY2023
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult CAHPS Report MY2023

EQR Survey Validation Worksheet

Plan Name	Select Health
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2023
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2023
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Child CAHPS Report MY2023

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2023
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Child CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2023
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child response rate was 13.1% which is a decline from last year's rate. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2023

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey Child CAHPS Report MY2023
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CAHPS Report MY2023

EQR Survey Validation Worksheet

Plan Name	Select Health
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD WITH CCC
Validation Period	2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

Results Elements		Validation Comments and Conclusions
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child with CCC response rate was 15.2% which is a decline from the previous year's rate. Additionally, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child with CCC CAHPS Report MY2023

Attachment 4: Assessment of Quality Improvement Plans from Previous EQR

ASSESSMENT OF QUALITY IMPROVEMENT PLANS FROM PREVIOUS EQR

Select Health 2023 Quality Improvement Plan

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
PROVIDER SERVICES			
II B. Adequacy of the Provider Network			
2. Practitioner Accessibility 2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.			
As part of the annual EQR process for Select Health Plan, a provider access study was performed focusing on PCPs. A list of current providers was given to Constellation by Select Health, from which a population of 2,802 unique PCPs were found. A sample of 210 providers were randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. In reference to the results of the Telephone Provider Access Study, conducted by Constellation, calls were successfully answered 55% of the time (107 out of 193) when omitting calls answered by personal or general voicemail messaging services. The success rate declined from last year's rate of 60%. When compared to last year's results of 60%, this year's study rate of 55% was a non-significant decrease in successful calls (p = .317). For those not answered successfully (n= 86 calls), 54 (63%) were due to the physician no longer being active at that location; 28 (33% were due to a wrong number, hold time longer than five minutes, or busy signal, and four were due to call not being answered (5%).	The Select Health of SC's (SHSC) Provider Directory Workgroup will continue to identify a process to review and update provider information. The workgroup will also work on identifying additional opportunities to maintain an accurate listing of providers and reeducate providers on all required appointment access standards. 12/15 *<u>SHSC Response:</u> The Provider Network Account Executives (AEs) are responsible for reviewing a minimum of 30 groups in their respective areas per month. A provider list, based on most current provider directory, is used by the AEs to review with each group. All updates are sent to the provider enrollment team for updating the system. The data reviewed by the AEs includes provider names currently listed in the directory, if there are new are termed providers in the group, address, and phone numbers, accepting new patients and age range of members seen.* *A Provider Directory Validation survey is also completed annually to determine accuracy of provider data. Results from the 2023 survey indicated that all audit elements surveyed exceeded the goal of 85%. Additionally, provider directory data for other provider specialties are reviewed based on business need. For example, all of the Physical Therapy, Occupational Therapy and Speech Therapy*		✓

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Of 107 providers successfully contacted, 103 (96%) accepted Select health and four (4%) did not accept Select Health. Of the 103 who are accepting Select Health, 74 (72%) are accepting new patients; 29 (28%) are not accepting new patients. A routine appointment was available within the contract requirements (30 days) for 26 (35%) of the 74 that are accepting new patients and outside the required timeframe for 48 (65%). *Quality Improvement Plan: Continue current processes that are conducted to update and validate provider contact information. Look for additional ways to improve provider contact information, such as increasing the frequency of monitoring and verifying provider contact information. Also, reeducate all providers about required appointment access standards.*	*providers are in the process of being reviewed to ensure accuracy including data elements such as address, phone number and age of patients seen. Additionally, any data updates submitted through the online provider directory are routed to the assigned AE to review, validate and update as needed. See attached Provider Directory Accuracy Report TAB 02A and Provider Directory Validation Memo TAB 02B.* *In addition, A revised and expanded Provider Directory Workgroup is being established to improve the accuracy of the provider data listed in the provider directory. The first meeting is set up for the week of 12/18/23.* *SHSC RESPONSE: Meeting Agendas with notes have been provided for the Provider Data Workgroup held between the departments Provider Network Operations and Provider Network Management. An agenda has been provided for at least one meeting held within a quarter. See meeting agendas with notes TABS 02C-TAB 02G.* *SHSC RESPONSE: The changes being discussed will be to the revised and expanded workgroup, which the goal of is to establish a timeframe and best approach to survey providers. It will also* identify which providers are most critical for review. The first meeting is scheduled for 12/18/23. *SHSC RESPONSE: The revised and expanded workgroup is working on creating new innovations for maintaining an accurate list of providers. These interventions will involve multiple departments to assist in the process for updating provider data. One of the problematic items that the work group will focus on is providers not communicating when they have moved, changed address, or removed or added a new provider.* *SHSC RESPONSE: The plan will include a notice about provider updates in the provider newsletters and within our provider portal*		

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
	for any reeducation to providers regarding appointment access standards as changes are made. *SHSC RESPONSE: The plan has implemented a quality improvement project to identify provider contact information through the revised Work Group.*		
UTILIZATION MANAGEMENT			
V A. The Utilization Management (UM) Program			
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: 1.7 the mechanism to provide for a preferred provider program.			
Select Health's Policy UM.318S, Preferred Provider Program, indicated the Preferred Provider Program is designated for providers to have clinical review requirements waived and annually, Medical Directors conduct retrospective chart and claims audits for providers to maintain eligibility within the program. However, during onsite discussion, Select Health stated that they did not have a Preferred Provider Program. The health plan described two processes they have implemented such as Contract Exceptions and Primary Care Physician Auto Assignment. Neither of these two processes are communicated to the providers for participation and do not correspond with the processes outlined in Policy UM.318S, Preferred Provider Program. *Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy UM.318S Preferred Provider Program.*	SHSC is evaluating the current policy and process for Preferred providers and will adjust/update to align with the SCDHHS contract requirement and the current processes. The Preferred Provider policy number UM.318S and the process documents will be updated and communicated to providers by the end of 1st quarter 2024.	✓	
V B. Medical Necessity Determinations			
6. Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.			

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
Select Health's website contains information regarding covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. There was no information regarding when the negative PDL changes were published on the website. The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3,* requires the health plan's Pharmacy & Therapeutics Committee to approve the PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plan's website at least 30 days prior to implementation. Select Health's changes posted on the website did not appear to meet this requirement. *Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Select Health's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*	SHSC's website includes a copy of the 2023 Preferred Drug List Changes. This list notes the drug changes and the effective date for those changes. Going forward, the date stamp of the posted date will be added to the website. The Pharmacy team is working with the Communications Team. PerformRx, the pharmacy benefit manager for Select Health, reviews and maintains the Preferred Drug List. The Pharmacy & Therapeutics Committee also provides input for the pharmacy program and has met four times this year. The goal of the committee is to approve pharmacy policies, criteria review, and review the preferred drug list changes.	✓	
V C. Appeals			
2. The MCO applies the appeal policies and procedures as formulated.			
The sample of appeal files reviewed found issues with seven files. • For one file, Select Health extended an expedited appeal request without notifying the member as required by the *SCDHHS Contract, Section 9.1.6.1.5* and Policy MMS.100, Member Grievances and Appeals Process. Also, the acknowledgement letter sent to the member incorrectly indicated that the appeal would be resolved within 30 days as opposed to the 14-day extension timeframe. The reason for the extension was not documented in the appeal notes reviewed or conveyed to the member. • The acknowledgement letter was not sent for one standard appeal and five expedited appeal requests. During the onsite, Select Health indicated a verbal acknowledgement is given for expedited appeal requests. However, Policy MMS, 100, Member Grievances and Appeals Process, Section IV, Expedited Appeals,	All extension cases will be monitored on our dashboard for communication (date and time) with member / provider and extension letters are completed and mailed (date and time). Acknowledgement letters are not sent for expedited cases but instead a verbal notification is provided. We will update this information in our policy for state approval. If the case will not allow us to change this in the policy, we will need to develop a new acknowledgment letter for expedited. The appeals review process has been updated for all letters. Documentation of date and time from Client Letter must be documented in the case and copy of letter uploaded to episode before the cases is closed.	✓	

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
indicates the Appeals Administrator will create and mail a member's acknowledgment letter. *Quality Improvement Plan: Ensure that acknowledgement letters are sent to members in accordance with Policy MMS.100, Member Grievances and Appeals Process. Develop a process to monitor a sample of appeal files to ensure all the requirements for processing appeals are met. Conduct a root-cause analysis when deficiencies are found so interventions can be developed to address the deficiencies.*			