South Carolina External Quality Review

COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR '21-22

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCO) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) contracted with The Carolinas Center for Medical Excellence (CCME), an external quality review organization (EQRO), to conduct External Quality Review (EQR) for all managed care organizations (MCOs) participating in the Healthy Connections Choices and Healthy Connections Prime Programs. The MCOs, also referred to as health plans, include:

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

CCME also conducted EQR for SC Solutions, a primary care case management program providing care coordination for the Medically Complex Children's Waiver program.

The purpose of external quality reviews is to ensure that Medicaid enrollees receive quality health care through a system that promotes timeliness, accessibility, and coordination of all services. This is accomplished by conducting the following activities for each MCO: validation of performance improvement projects, performance measures, and surveys; review for compliance with state and federal regulations; and provider access studies. This report is a compilation of the findings of the annual reviews conducted during the 2021 - 2022 review cycle.

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:

- 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)*
- Sub contractual 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 access the MCO's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into seven areas.

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation
- State Mandated Services

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

Documentation specific to the organizational structure and business management approaches was reviewed for each health plan. It was noted most of the health plans had sufficient staff in place to ensure services required by SCDHHS are provided to members. Select Health confirmed during onsite discussion that recruiting efforts are underway to fill 15 vacant positions in the Customer Services area. Molina addressed changes needed for the Organizational Chart since the date of the EQR submission to CCME. There was discussion regarding current vacant positions and the process for filling identified positions. Job functions of backfilled positions were discussed while the recruiting process is completed.

Each of the MCOs submitted policies and procedures, training documents, and a Compliance Plan describing processes to educate employees, subcontractors, members, and providers about reporting options, roles, and rights specific to fraud, waste, and abuse (FWA). Approaches for identifying, preventing, investigating, and taking corrective action against any provider or member who is suspected of participating in FWA activities were outlined.

Health plan Compliance Committees meet quarterly and have been established to monitor risks, provide training and education for employees and members; and review data reported to ensure compliance with policies and procedures. Compliance Committee Charters outline member roles and responsibilities. The health plans monitor and conduct periodic audits to ensure adherence to written policies, procedures, and evaluation of compliance with regulatory standards. Compliance Officers are identified in the MCOs' Organizational Charts.

Policies, procedures, and training materials are in place for employees and providers outlining expectations of compliance with all applicable laws with respect to uses and disclosures of Protected Health Information (PHI).

The Information Systems Capabilities Assessment (ISCA) documentation review indicates that each MCO provides an overview of the systems, processes, and polices that satisfy the requirements of the *SCDHHS Contract*.

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 MCOs have established committees that use a peer-review process to render credentialing determinations. The committees have defined meeting frequencies, established membership, and are chaired by the plan Medical Directors/Chief Medical Officers. Network providers with various specialties are included as members of the committees. Recommendations were given to the MCOs to address identified findings related to documentation of attendance expectations for the committees, outdated or incorrect documentation of committee members, and recruiting additional practitioners to serve on the committees. Select Health committee documentation reflected several members did not meet the attendance expectation.

Policies and procedures describe processes and requirements for initial and ongoing credentialing. Identified policy issues included discrepancies in provider appeal rights related to credentialing (Healthy Blue) and failure to include all required credentialing elements and processes (Humana). A sample of provider credentialing and recredentialing files was reviewed for each MCO. Only minor, isolated findings were noted for ATC, Healthy Blue, Molina, and Select Health, and it was clear that these MCOs corrected all issues identified during the previous EQR. A significant number of issues were identified in Humana's files related to inappropriate dates on letters, failure to collect collaborative agreements for nurse practitioners, and lack of evidence of required queries. It was evident that Humana did not adequately address the Quality Improvement Plan from the previous year's Readiness Review.

The MCOs define provider geographic access standards, appointment access standards, and processes for monitoring network adequacy in policies and procedures. All the MCOs evaluate their networks at least annually and work to address any identified network gaps. However, ATC's Geo Access mapping did not include all SCDHHS-designated Status 1 provider types, a repeated finding from the previous EQR. For four of the five plans (ATC, Healthy Blue, Humana, and Select Health), issues with documentation of appointment access standards and/or processes for monitoring provider compliance were noted in policies and procedures. Also, Select Health was using an inappropriate timeframe to evaluate provider compliance with routine primary care appointment access standards. This is a similar issue from the previous EQR.

The MCOs have established Cultural Competency programs, educate their providers about cultural competency, and include information and additional resources on their websites. Information on ATC's website was found under a heading of "Medicare-Medicaid Plan (MMP) Education and Training," and several hyperlinks in the Cultural Competency information in Humana's Provider Manual were non-functional.

Regarding requirements for Provider Directories, some MCO policies failed to address all required elements, such as age groups, office hours, website addresses, and ability to accommodate members with physical disabilities. Molina's print Provider Directory did not include practitioner website addresses, a repeat finding from the previous EQR.

For the Telephonic Provider Access Study conducted by CCME, Healthy Blue received a score of "Met" and three plans (ATC, Molina, and Select Health) received a score of "Not Met" for the standard requiring improvement in the results of the study. For Humana, the standard was not evaluated as this is the baseline year.

All plans conduct initial orientation and ongoing education for practitioners within their networks. Issues with Humana's (Provider Training)-009 policy and Molina's Provider and Practitioner Education procedure (MHSC-PS-010) were noted, as well as errors in member benefit information in Humana's Provider Manual.

The MCOs define medial record documentation standards in policy and educate network providers about medical record maintenance, storage, and required medical record documentation elements. However, Select Health's policy and its related attachment did not address all required medical record documentation elements. Issues noted with documentation of processes to assess provider compliance with medical record documentation standards were noted for three of the five MCOs. Each of the MCOs routinely conducts provider medical record audits with results analyzed, reported to quality committees, and used for quality improvement activities.

Member Services

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

The MCOs provide new members with information needed to understand health plan processes and requirements, member benefits, contact information, etc. Ongoing member education is provided through Member Handbooks, mailings, newsletters, and websites. Members may contact the Member Services call centers and 24-hour nurse lines for additional information and assistance. The MCOs educate members about available preventive health and disease management services and encourage members to participate in available wellness and preventive services. Of note, Humana's Member Handbook did not include full benefit information for several services.

The MCOs conduct annual Member Satisfaction Surveys using certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors and use survey results for quality improvement. Humana's survey validation was not conducted as survey results were not yet available. Survey response rates for Healthy Blue improved from the previous year; however, response rates for ATC, Molina, and Select Health decreased.

Grievance processes and requirements are detailed in health plan policies and procedures, Member Handbooks, Provider Manuals, and websites. A sample of grievance files was reviewed for each health plan. For ATC, Molina, and Select Health, no issues were identified. For Healthy Blue, grievance files reflected that the plan does not consistently follow policy for the grievance acknowledgement timeframe. Humana's grievance files revealed the plan did not consistently meet the required timeframes for sending acknowledgement letters and for grievance resolution. The health plans track, categorize, and analyze grievances for trends, patterns, and opportunities for improvement. Grievance data are routinely reported to appropriate Quality committees.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

The MCOs are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the health plans in SC included review of the programs' structures, work plans, and program evaluations, as well as validations of performance measures and performance improvement projects.

Each MCO provided a program description that explains the QI programs' structure, scope, goals, accountabilities, and resources. On an annual basis, the QI program descriptions are reviewed and updated as needed. In addition, the MCOs develop an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. The work plans are reviewed and updated at least quarterly. Any previously identified issues and opportunities are addressed in the updates. The review of the work plans found some areas needed improvements. Molina's and Healthy Blue's QI Work Plans were missing several benchmarks or goals.

A committee charged with oversight of the QI programs has been established for each plan. The committees review data received from QI activities to ensure performance meets standards, and make recommendations as needed. Membership for the quality committees included the health plans' senior leadership, department directors and managers, and other plan staff. Network providers of varying specialties are included as voting members for all the health plans except Humana.

The health plans provide information and several resources about the QI Programs to members and practitioners via their websites and/or newsletters. Network providers are informed of their QI performance data on key quality measures via provider report cards, gaps in care reports delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and/or secure fax.

Performance Measure Validation

MCOs are required to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the performance measures (PMs) reported, CCME uses the CMS Protocol, *Validation of Performance Measures*. All plans use a HEDIS® certified vendor or software to collect and calculate the measures, and all were found to be "Fully Compliant." Health plan rates for the most recent review year and the statewide average are reported in in the Quality Improvement section of this report. *Table 1: HEDIS Measures with Substantial Increases or Decreases* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year. The comparison of rates from MY2019 to MY2020 highlighted in green indicate a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease of more than 10 percent.

Table 1: HEDIS Measures with Substantial Increases or Decreases

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Effectiveness of Care: Prevention and Screening					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)					
BMI Percentile	73.48%	75.00%	73.24%	79.15%	75.22%
Counseling for Nutrition	61.07%	63.66%	61.07%	69.10%	63.73%
Counseling for Physical Activity	57.18%	62.37%	56.69%	65.58%	60.46%
Effectiveness of Care: Respiratory Conditions					
Appropriate Testing for Pharyngitis (cwp)					
65+	50.00%	NA*	NA*	NA	NA
Pharmacotherapy Management of COPD Exacerbation (pce)					
Systemic Corticosteroid	69.26%	69.00%	71.09%	74.31%	70.92%
Asthma Medication Ratio (amr)					
19-50 Years	49.66%	55.97%	47.78%	56.47%	52.47%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	Statewide Average
51-64 Years	48.24%	51.39%	48.09%	59.30%	51.76%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (cbp)	51.34%	48.18%	46.96%	53.53%	50.00%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.89%	77.14%	77.14%	79.10%	75.57%
Statin Therapy for Patients With Cardiovascular Disease (spc)					
Statin Adherence 80% - 21-75 years (Male)	62.57%	59.68%	62.80%	63.17%	62.06%
Statin Adherence 80% - 40-75 years (Female)	62.71%	58.54%	60.50%	63.48%	61.31%
Statin Adherence 80% - Total	62.63%	59.14%	61.67%	63.33%	61.69%
Effectiveness of Care: Diabetes					
Comprehensive Diabetes Care (cdc)					
HbA1c Poor Control (>9.0%)	44.04%	51.09%	49.39%	56.93%	50.36%
Eye Exam (Retinal) Performed	47.20%	35.52%	52.55%	43.31%	44.65%
Statin Therapy for Patients With Diabetes (spd)					
Statin Adherence 80%	59.59%	49.43%	58.33%	56.70%	56.01%
Effectiveness of Care: Behavioral Health					
Follow-Up After Hospitalization for Mental Illness (fuh)					
6-17 years - 7-Day Follow-Up	50.89%	52.09%	57.26%	53.87%	53.53%
Follow-Up After Emergency Department Visit for Mental Illness (fum)					
6-17 years - 7-Day Follow-Up	55.56%	47.47%	56.52%	58.52%	54.52%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)					
13-17 years - 30-Day Follow-Up	NA	25%	33.33%	32.65%	30.33%
13-17 years - 7-Day Follow-Up	NA	12.50%	20%	16.33%	16.28%
18-64 years - 30-Day Follow-Up	42.64%	35.75%	43.62%	41.92%	40.98%
18-64 years - 7-Day Follow-Up	23.35%	25.12%	29.79%	29.34%	26.90%
Total - 30-Day Follow-Up	40%	35.35%	42.86%	40.73%	39.74%
Total - 7-Day Follow-Up	22.67%	24.65%	29.06%	27.68%	26.02%
Pharmacotherapy for Opioid Use Disorder (pod)					
16-64 years	40.94%	40.89%	24.26%	47.21%	38.33%
Total	40.31%	40.89%	24.39%	47.21%	38.20%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)					
Blood glucose testing - 1-11 Years	32.12%	37.39%	33.64%	40.27%	35.86%
Cholesterol Testing - 12-17 Years	30.77%	22.43%	28.86%	39.19%	30.31%
Access/Availability of Care					
Initiation and Engagement of AOD Dependence Treatment (iet)					
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	59.36%	56.79%	57.87%	61.93%	58.99%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	31.53%	35.41%	33.33%	37.93%	34.55%

Measure/Data Element	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Opioid abuse or dependence: Initiation of AOD Treatment: Total	59.46%	56.29%	58.09%	62.25%	59.02%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	31.45%	35.10%	33.16%	38.04%	34.44%

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validation of Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project.

Each health plan is required to submit PIPs to CCME for review annually. CCME validates and scores the submitted projects using the CMS designed protocol to evaluate the validity and confidence in the results of each project. Nine projects were validated for the five health plans. Humana did not submit any projects for validation; per onsite discussion, the health plan is reviewing baseline data and other data sources and forming work groups to begin discussions regarding topics for PIPs.

Results of the validation and project status for each project are displayed in *Table 2: Results of the Validation of PIPs*. Interventions for each project are included in the Quality Improvement Section of this report.

Table 2: Results of the Validation of PIPs

Project	Validation Score	Project Status
ATC		
Provider Satisfaction	100/100=100% High Confidence in Reported Results	The objective for the Provider Satisfaction project is to identify opportunities and implement initiatives to positively impact provider satisfaction and meet or exceed the plan's goal of the 75th percentile as defined by the SPH Analytics Medicaid Book of Business. The 2018, 2019, and 2020 rates were included in the PIP report for Overall Satisfaction, with ATC showing a reduction from 73.4% in 2018 to 57.9% in 2019, which then improved to 68% in 2020. This is below the goal rate of 75th percentile for Book of Business.
Hospital Readmissions	80/80= 100% High Confidence in Reported Results	The health plan's overall rate for readmissions for the previous twelve months was 18.0% with several months during that period having a rate greater than 18.0%. After analysis of the data, ATC's department leaders and QIC identified an opportunity for improvement in reducing readmissions and a PIP was approved.

Project	Validation Score	Project Status
		The goal set internally for this PIP is to reduce the readmission rate to 17.5%. Data were reported for the baseline and Remeasurement 1. The results show a decline in readmissions from 18% to 16.2% in the 2020/2021 measure. These results indicate improvement in reducing readmission and exceed the goal rate of 17.5%.
Healthy Blue		
Comprehensive Diabetes Care	93/93= 100% High Confidence in Reported Results	The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. Both indicators showed baseline rates. The HbA1C >9% rate was 51.09% with a goal of 58.75%. The Retinal eye exam indicator rate was 35.35% with a goal of 37.35%.
CAHPS – Child with Chronic Conditions Customer Service	88/93= 95% High Confidence in Reported Results	This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass. It was noted the current interventions seem to focus on improving response rates and reaching a larger audience, but not necessarily improving customer service scripts or resources.
Molina		
Improving Encounters Acceptance Rates	73/74=99% High Confidence in Reported Results	The focus for this PIP is to improve the encounter acceptance rates for professional (837P) encounters. This PIP has two indicators. The initial acceptance rate was 97.5% at baseline and declined to 96.9% at year 1 with a goal of 100%. For the 837P taxonomy rejection rate, the baseline was 2.63% and increased to 2.82%. The target goal for this indicator was set at 2%. Both indicators did not show improvement. It was recommended that Molina continue to monitor the indicator rates to determine if logic adjustment and rejected encounter reviews improve the rates toward 100% for initial acceptance rate.
Child and Adolescent Well-Care Visits Program	72/72=100% High Confidence in Reported Results	Molina is implementing the Child and Adolescent Well-Care Visits Program to offer eligible Members and Providers incentives for Members receiving a Well-Visit or Comprehensive Well-Visit (for Ages 3 to 21). The baseline measurement rate for this PIP was 43.16% using the administrative data. The interventions included member and provider education and outreach, incentive programs, and transportation assistance.
Immunizations for Adolescents Program	72/72=100% High Confidence in Reported Results	Molina chose this PIP to target rural and urban areas across SC to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV-related cancers. The baseline rate for this PIP was reported as 27.98%.

Project	Validation Score	Project Status
Select Health		
Comprehensive Diabetes Care Outcomes Measures	90/91= 99% High Confidence in Reported Results	The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group. The Comprehensive Diabetes Care control measure A1c slightly improved while the BP measure continued to trend negatively in 2020. Both measures were impacted by the COVID-19 pandemic and did not meet the plan's goal for the 75th percentile. The A1c <8 measure showed a 3.56% increase from the previous year and met the plan's goal of a 2% increase. The blood pressure control measure demonstrated an 8.04% decline and did not meet the goal. The member incentives continued and resulted in a less than 1% return rate and therefore did not indicate an improvement. The results of this PIP would indicate that the incentive intervention was not effective.
Well-Care Visits for Children and Adolescents in Foster Care in South Carolina	91/91=100% High Confidence in Reported Results	The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase the compliance with well-care visits for the children and adolescents in foster care. During the pilot project, Select Health found there was no defined process point for sharing health, behavioral health, dental history, or detail prior to placement and no process for sharing information between Select Health and the SC Department of Social Services (SCDSS) while the child is in placement. Another significant finding of the Health Care Pilot and Case Process Review was that, even though virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) well-child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits. Two of three (66%) well-child visit measures demonstrated improvement from the CY2019 baseline year: Adolescent Well-Care Visit (awc) and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34). One of three (33%) well-child visit measures, Well-Child Visits in the First 15 Months of Life (w15) 6+ Visits, experienced a small decrease from the CY2019 baseline year. All three measures (awc, w15, and w34) experienced substantial improvements from CY2018 to CY2020 — 5.94 percentage points,

Project	Validation Score	Project Status
		3.37 percentage points, and 9.43 percentage points, respectively. The wcv is a new measure for this PIP. Baseline rates were presented for 3-11 years, 12-17 years, 18-21 years, and total.

Utilization Management

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

Each MCO has a comprehensive Utilization Management (UM) Program Description along with numerous policies and procedures that guide staff in the implementation of utilization management activities for physical health, behavioral health, and pharmaceutical services for members in SC. The Medical Director at each plan oversees all aspects of the UM Program.

The MCOs use nationally recognized screening criteria, internal clinical review criteria, and other state established criteria for reviews of service authorization requests. Requests for services that do not meet medical necessity criteria or that require further medical review are routed to a physician reviewer. Only licensed physicians can deny a medical service or treatment.

Policies and UM Program Descriptions details the process for applying criteria and disseminating criteria to members and providers as requested. The timeframes for completing a service authorization request are included in policies and/or UM Program Descriptions. Humana had an issue with the timeframe for completing a non-expedited review. Each health plan assesses consistency in criteria application and decision-making through inter-rater reliability (IRR) testing for physician and clinical reviewers for medical and behavioral health services. CCME found that Humana had not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.

All MCOs provide coverage for medications through their Pharmacy Benefit Managers. The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3,* requires negative preferred drug list changes be published on the health plans' websites at least 30 days prior to implementation. The changes posted by ATC, Healthy Blue, Humana, and Molina did not meet this requirement.

CCME reviewed a sample of approval and denial files received from each health plan. This review confirmed the health plans used appropriate criteria and requests that do not

meet criteria were sent to a physician to render a determination. The files reflected timely decisions and notifications. For the denials, Adverse Benefit Determination letters were written in appropriate language for ease of member understanding, contained the rationale for the denial along with references to the criteria used, and supplied information on how to request an appeal.

The health plans in SC are responsible for establishing a process for handling and responding to requests for an appeal of an adverse benefit determination made by the health plan. This process must meet the requirements outlined in the SCDHHS Contract and in federal regulations. All the health plans have policies that address the process for how appeals are handled. Molina's appeal process and policies require a standard appeal request received verbally to be followed by a written request. CCME informed Molina that this was no longer a requirement by SCDHHS and federal regulations, and this requirement should be removed.

The file review for Select Health reflected timely acknowledgement, resolution, and notification of determinations. The determinations were made by professionals with appropriate clinical experience. Resolution letters were written clearly and provided instructions for requesting a State Fair Hearing.

ATC, Healthy Blue, Humana, and Molina did not consistently process standard and expedited appeals according to guidelines in their policies and in federal regulations.

The MCOs' Care Management programs incorporate care management, care coordination, transition management, and prevention activities to ensure appropriate care for members of various risk levels, assist members in meeting needs, and improving outcomes when possible. Each of the plans has program descriptions that include information about program purpose, scope, member identification, screenings, stratification, and assessments. Policies and procedures provide additional detail about Care Management (CM) processes and requirements. A few minor issues were noted in the program descriptions, policies, and procedures related to Targeted Case Management Services (ATC), program structure (Humana), and assessment processes and frequency of outreach (Molina).

The MCOs routinely assess member satisfaction with the CM programs and conduct overall program evaluations. Results are used for quality improvement.

Care Management files reflected care management and coordination activities are conducted as required. For one ATC file, the member verbalized concerns with food availability and with money for food, but assessment notes indicated no economic or social conditions had been identified and the care plan did not address the member's concern.

The health plans are required to monitor and analyze utilization data to identify trends or issues that may provide opportunities for quality improvement. Four of the five health plans submitted information on quarterly or annual trending of utilization data across medical and behavioral health services. Policies for over- and under-utilization were included within the utilization management departments, though evaluations and actions to improve utilization measures were stated to be a multi-department effort for all plans.

Humana's desk materials did not contain specific policies or action steps planned for addressing over and under-utilization. This was an issue identified during Humana's Readiness Review and not corrected.

Delegation

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

Health plan policies provide detailed information about processes for delegation of activities to external entities, including pre-delegation assessment, routine monitoring, annual oversight, delegation agreements, etc. Written delegation agreements are implemented with each approved delegate that specify the activities delegated, monitoring and oversight, requirements for sub-delegation, reporting requirements, performance expectations, and actions that may be taken because of unsatisfactory performance.

Each of the MCOs provided documentation of ongoing monitoring and annual oversight of delegates. Isolated issues were noted, such as untimely completion of oversight activities (ATC), failure to monitor and assess all credentialing requirements during oversight of credentialing delegates (Healthy Blue), and unclear documentation on Humana's Credentialing Annual Audit Tool. No issues were noted with annual oversight and ongoing monitoring for Molina and Select Health. Deficiencies identified during the previous EQRs for Healthy Blue, Humana, and Select Health were corrected; however, a similar issue was noted during the most recent EQR for Healthy Blue.

State Mandated Services

42 CFR § Part 441, Subpart B

Each of the health plans has an Early and Periodic Screening Diagnostic, and Treatment (EPSDT) Program that follows the American Academy of Pediatrics periodicity schedule. Four of the MCOs (ATC, Healthy Blue, Molina, and Select Health) have established processes to monitor provider compliance with administering recommended immunizations and providing EPSDT services through medical record reviews, claims and encounter data monitoring, etc. For Humana, no policy and/or procedure was identified describing processes for monitoring provider compliance specific to administering immunizations and performing EPSDT or well-care services for members, and Humana provided no evidence of tracking provider compliance with immunizations and EPSDT services.

All the MCOs ensure core benefits and services are provided to members as required by the SCDHHS Contract and Federal Regulations.

Every plan is required to address deficiencies identified in the previous EQR; however, ATC, Healthy Blue, Humana, and Select Health were found to have uncorrected deficiencies from the previous EQR.

SC Solutions

To access the Solutions' compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into four areas.

- Administration
- Provider Services
- Quality Improvement
- Care Coordination/Case Management

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

Administration

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

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

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

All employees are screened upon hire to determine if they have been excluded from participation in any state or federal programs. Policy CHS.COMP.ALL.02.01, OIG and

Other Exclusion List Checks, indicates the Human Resources Department performs the initial exclusion review and the Compliance Department performs monthly exclusion review. CCME reviewed a sample of personnel files and found the initial screenings had been conducted. However, the files lacked evidence of ongoing monthly screenings. Solutions provided additional screenshots of the monthly queries to demonstrate the exclusion screenings were conducted. For the review period (June 2021 through May 2022), none of the files contained 12 months of screenings.

Other findings in the personnel files included a lack of purified protein derivative (PPD) skin testing results for clinical staff and no evidence of Health Information Portability and Accountability Act (HIPAA) and Compliance training. Solutions indicated that because clinical staff are not conducting face-to-face visits due to COVID-19, the PPDs were not required. The roster of employees completing the required HIPAA and Compliance training was provided after the onsite.

All staff receive HIPAA and information security training prior to being allowed access to Protected Health Information. On a continuing education basis, all employees receive training at least annually.

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

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

Provider Services

Solutions' provider network was closed at the time of the review, but it was anticipated that the organization would reopen the network to new providers soon. Appropriate processes are in place for initial provider orientation, which covers a range of topics to acclimate providers to the MCCW program and requirements. The Provider Manual, available on the website, is the main resource for network providers, and includes key contact information, goals of the MCCW, program processes and requirements, and information about the role of providers caring for MCCW participants. The Provider Manual also addresses requirements for medical record documentation, retention, and storage. Free language services are available, and the Provider Manual includes both toll-free telephone and teletypewriter (TTY) numbers to access language services, which

include qualified verbal and sign language interpreters. Member materials are available in alternate formats, such as large print, braille, audio, etc.

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

Quality Improvement

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

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

The Compliance & Quality Management Committee is the local committee responsible for oversight of all aspects of the QI Program. The committee is chaired by the Chief Medical Officer. Voting members include the Chief Compliance Officer, Manager of Medical Informatics, the Quality Coordinator, and other Team Leads. In 2021 the committee only met in the 1st and 3rd quarters. For 2022, the committee is on track for meeting quarterly.

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

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

Care Coordination/Case Management

Solutions' Executive Director/Chief Medical Officer, who reports to the CHS Board of Directors, oversees program operations and is responsible for ensuring the goals and objectives of SCDHHS and Solutions are aligned. Solutions' Medical Director, currently a vacant position filled on an interim basis by the Chief Medical Officer, provides clinical oversight/decision-making and works closely with the Directors of Care Coordination. The Medically Complex Children's Waiver Program Description provides an overview of the organization, program structure and oversight, goals, and objectives. Program policies provide details and processes to guide staff that conduct daily Care Coordination and Case Management activities. Solutions continues to operate under the Appendix K Waiver due to the Federal Health Emergency for COVID-19; therefore, all contacts with participants, responsible parties, and providers are conducted virtually or by telephone. Participants and caregivers are included in the review and revision of Person Centered Service Plans.

The review of program policies and other documentation revealed that, overall, program requirements and processes are well-documented. However, two issues were noted during the policy review: 1.) policies did not address discharge planning for hospitalized participants, and 2.) did not completely document processes for reporting suspected participant abuse, neglect, or exploitation. The review of sample Care Coordination files revealed only one minor issue in that some Growth and Development Assessment forms were not dated.

Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, CCME requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected. During the current EQR, CCME assessed the degree to which each health plan implemented the actions to address deficiencies identified during the previous EQR. Four of the five health plans (ATC, Healthy Blue, Humana, and Select Health) were found to have uncorrected deficiencies from the previous EQR. These were related to:

- Failure to include all required Status 1 providers in Geo Access mapping (ATC).
- Failure to follow health plan policy guidelines for sending appeal case files to members within 10 calendar days (Healthy Blue).
- Failure to collect full collaborative agreements for nurse practitioners at initial credentialing and recredentialing (Humana).

- Inappropriately dating letters notifying providers of credentialing and recredentialing determinations prior to the date the determination was made (Humana).
- Lack of a specific policy or action steps for addressing the monitoring of over- and under-utilization (Humana).
- The timeframe for PCP appointment access and lack of improvement in the Telephonic Provider Access Study conducted by CCME were identified again during the current EQR (Select Health).

Conclusions

For the 2021-2022 EQRs overall, the health plans met all the requirements for Coordination and Continuity of Care *(§ 438.208, § 457.1230)*, Confidentiality *(§ 438.224)*, Practice Guidelines *(§ 438.236, § 457.1233)*, and Health Information Systems *(§ 438.242, § 457.1233)*.

Table 3: Compliance Results for Part 438 Subpart D and QAPI Standards provides an overall snapshot of compliance scores specific to each of the 11 Subpart D and QAPI standards.

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

Standards	Category	Total Number of Standards	ATC		Healthy Blue		Humana		Molina		Select Health	
			Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score
Provider Services, Section II. B. Adequacy of the Provider Network	Availability of Services *(§ 438.206, § 457.1230)* and Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	8	6	75%	7	87.5%	7	**100%	7	87.5%	6	75%
Utilization Management, Section V. D. - Care Management	Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	8	8	100%	8	100%	8	100%	8	100%	8	100%
Utilization Management, Section V. B. - Medical Necessity Determinations	Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	14	13	93%	13	92.8%	11	79%	13	92.8%	14	100%
Provider Services, Section II. A. - Credentialing and Recredentialing	Provider Selection *(§ 438.214, § 457.1233)*	39	39	100%	39	100%	30	77%	39	100%	39	100%
Administration, Section I. E. - Confidentiality	Confidentiality *(§ 438.224)*	1	1	100%	1	100%	1	100%	1	100%	1	100%

Standards	Category	Total Number of Standards	ATC		Healthy Blue		Humana		Molina		Select Health	
			Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score
Member Services, Section III. G. - Grievances Utilization Management, Section V. C. - Appeals	Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	20	20	100%	18	90%	18	90%	18	90%	20	100%
Delegation Section	Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	2	2	100%	1	50%	2	100%	2	100%	2	100%
Provider Services, Section II. D. - Primary and Secondary Preventive Health Guidelines Provider Services, Section II. E. - Clinical Practice Guidelines for Disease and Chronic Illness Management	Practice Guidelines *(§ 438.236, § 457.1233)*	11	11	100%	11	100%	11	100%	11	100%	11	100%

2021–2022 External Quality Review

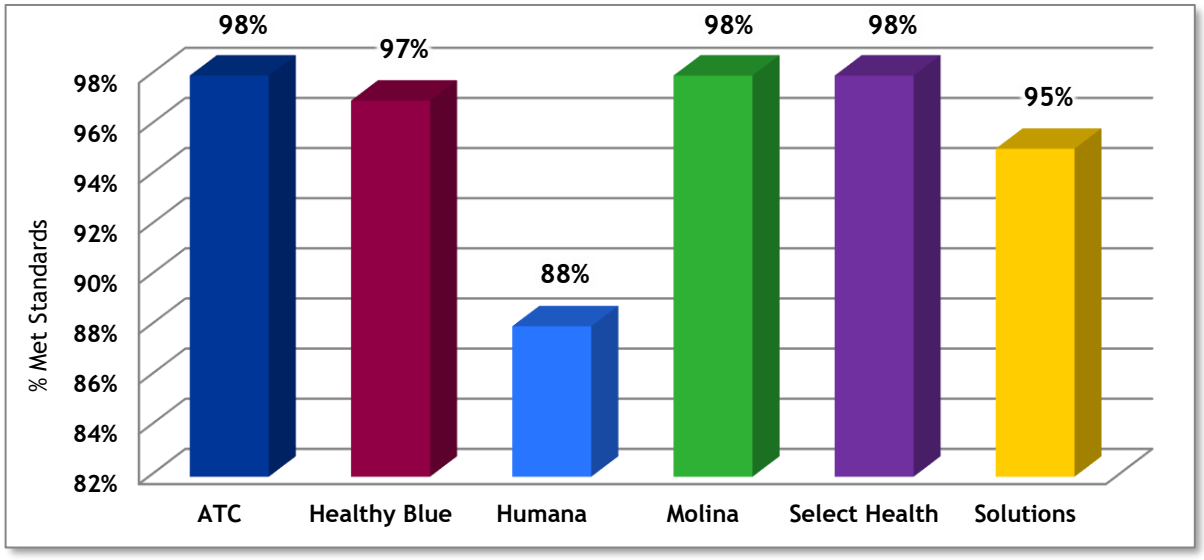
Standards	Category	Total Number of Standards	ATC		Healthy Blue		Humana		Molina		Select Health	
			Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score	Number of Standards Scored as "Met"	Overall Score
Administration, Section I. C. – Management Information Systems	Health Information Systems *(§ 438.242, § 457.1233)*	7	7	100%	7	100%	7	100%	7	100%	7	100%
Quality Improvement Section	Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	14	14	100%	14	100%	10	**91%	13	92.8%	14	100%

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

*** The Standards Not Evaluated were removed from the denominator and numerator.*

The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2021 – 2022 EQRs.

Figure 1: Percentage of Met Standards



Scores were rounded to the nearest whole number

The following table provides an overview of the scoring for each section of the EQR.

Table 4: Overall Scoring

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
Administration						
ATC	40	0	0	0	40	100%
Healthy Blue	40	0	0	0	40	100%
Humana	38	2	0	0	40	95%
Molina	40	0	0	0	40	100%
Select Health	40	0	0	0	40	100%
Solutions	33	1	0	0	34	97%
Provider Services						
ATC	74	1	1	0	76	97%
Healthy Blue	75	1	0	0	76	99%
Humana	64	6	5	1	76	85%
Molina	75	0	1	0	76	99%
Select Health	73	2	1	0	76	96%
Solutions	5	0	0	0	5	100%

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
Member Services						
ATC	33	0	0	0	33	100%
Healthy Blue	32	1	0	0	33	97%
Humana	21	1	0	11	33	95%
Molina	33	0	0	0	33	100%
Select Health	33	0	0	0	33	100%
Quality Improvement						
ATC	14	0	0	0	14	100%
Healthy Blue	14	0	0	0	14	100%
Humana	10	1	0	3	14	91%
Molina	13	1	0	0	14	93%
Select Health	14	0	0	0	14	100%
Solutions	7	0	0	0	7	100%
Utilization/**Care Coordination						
ATC	44	1	0	0	45	98%
Healthy Blue	43	2	0	0	45	96%
Humana	38	6	0	1	45	86%
Molina	43	2	0	0	45	93%
Select Health	45	0	0	0	45	100%
**Solutions	13	1	1	0	15	87%
Delegation						
ATC	2	0	0	0	2	100%
Healthy Blue	1	1	0	0	2	50%
Humana	2	0	0	0	2	100%
Molina	2	0	0	0	2	100%
Select Health	2	0	0	0	2	100%
State Mandated Services						
ATC	3	0	1	0	4	75%
Healthy Blue	3	0	1	0	4	75%
Humana	1	0	3	0	4	25%
Molina	4	0	0	0	4	100%
Select Health	3	0	1	0	4	75%
Totals						
ATC	210	2	2	0	214	98.13%
Healthy Blue	208	5	1	0	214	97.20%

	Met	Partially Met	Not Met	Not Evaluated	Total Standards	*Percentage Met Scores
Humana	174	16	8	16	214	88%
Molina	209	4	1	0	214	98%
Select Health	210	2	2	0	214	98.13%
Solutions	58	2	1	0	61	95.08%

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

Coordinated and Integrated Care Organizations Annual Review

CCME conducted an EQR of the Coordinated and Integrated Care Organizations (CICOs) that participate in the Healthy Connections Prime program and provide services for the dual eligible Medicare/Medicaid population (MMP). Those plans include ATC, Molina, and Select Health. The EQR for Select Health was postponed at the request of SCDHHS and will be conducted in the fall of 2022. The EQR for ATC and Molina focused on network adequacy for home and community-based services (HCBS) and behavioral health providers, over- and under-utilization, and care transitions.

The process used by CCME for the EQR activities is based on the *CMS Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations*. To conduct the review, CCME requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over- and under-utilization data, and care transition files.

Provider Network Adequacy

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

CCME requested a complete list of all contracted HCBS providers currently in ATC's and Molina's networks. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. For ATC there were 41 counties documented as having members. Of the 287 services across 41 counties, 287 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%. ATC's Geo Access report showed that 99.7% of members had access to a psychiatrist and 14 members out of 4,734 did not have access, 99.9% of members have access to a psychologist with one member out of 4,734 without access, 99.9% of members have access to a social worker with one member showing no access, and 99.9% of members with access to a Community Mental Health Center (CMHC) using a requirement of one in 50 miles.

For Molina, there were 44 counties documented as having enrollment in the MMP Member Demographics 2021 file submitted by Molina. Of the 308 services across 44 counties, 308 met the minimum requirement resulting in a validation score of 100%, which is sustained from last year's rate of 100%. Molina also noted they had contracts in one additional county (Lancaster); however, no members were reported for that county. Molina's Geo Access report showed 100% of members had access to two behavioral health providers with an at least one CMHC included in that access area. Opioid treatment clinics were accessible to over 90% of members, with the exceptions of Allendale County, which showed only 2.9%, and Bamberg County which showed 66.1%. Molina provides transportation for members requiring treatment in those counties. All counties had 100% of members showing access to at least two types of behavioral health providers.

Evaluation of Over/Under Utilization

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

Care Transitions

CCME reviewed each CICOs program descriptions and policies related to care transitions. The CICOs were required to submit a file of enrollees who were hospitalized in an acute care setting, discharged, and readmitted to an acute care facility within 30 days. Based on the file received from each CICO, CCME requested a random sample of files for review. ATC and Molina continue to have transition of care issues. Files lacked documentation of the required follow-up assessments, reassessments, PCP notifications, and collaboration with facility Case Management or Discharge Planning staff. ATC's transitions that resulted in a move to a higher level of care are not analyzed to determine factors that contributed to the change and actions needed to improve outcomes.

Overall Recommendations

SCDHHS' requirement that MCOs must achieve NCQA accreditation, as well as its stipulations regarding the number of performance improvement projects that plans must conduct, indicate that the State is committed to a higher level of quality monitoring and accountability for its health plans. CCME recommends that SCDHHS continue to use measures from the annual network adequacy reviews, HEDIS audits, and performance improvement project validation as the primary means for assessing the Quality Strategy's success as applied to the integrated physical and behavioral health services delivered by

its health plans. The 2021 - 2022 EQR assessment results, including the identification of health plan strengths, weaknesses, and recommendations, attest to the positive impact of SCDHHS' strategy in monitoring plan compliance, improving quality of care, and aligning healthcare goals with priority topics. The Quality Strategy draft for May 2022 outlined several SCDHHS goals and objectives that align with CMS priority areas. Based on the goals in the Quality Strategy, CCME developed recommendations to allow MCOs to fulfill the objective of the Quality Strategy. *Table 5: SCDHHS Quality Initiatives* displays the recommendations for each initiative.

Table 5: SCDHHS Quality Initiatives

SCDHHS Quality Initiative	Recommendation
Ensure the quality and appropriateness of care delivered to members enrolled in managed care	Continue projects on health equity and value-based payment models for addressing social determinants of health to advance shared goals for priority social conditions and populations.
Assure Medicaid Members have access to care and a quality experience of care	Conduct access studies via EQRO and network submission assessments. Continue CAHPS survey deployment to understand member experiences with getting needed care and getting care quickly, as well as overall satisfaction with doctors and health plans.
Ensure MCO Contract Compliance	Continue annual comprehensive review of federal requirements through validation of quality activities including performance improvement projects, HEDIS performance measure calculations, and utilization management.
Manage Continuous Performance Improvement	Perform PIP reviews to ensure they achieve improvement in chosen outcomes and monitor for sustainment over time in clinical and nonclinical areas.
Conduct Targeted Population Quality Activities	Establish strategies and best-practice approaches to conducting activities that focus on sub-populations of members including postpartum care activities, behavioral health initiatives, and LTSS programs.

Assessment of Strengths and Weaknesses

The results of 2021-2022 EQR activities demonstrate that the health plans are well-qualified and committed to facilitating timely, accessible, and high-quality healthcare for members. The following tables provide an overview of strengths, weaknesses, and recommendations related to quality, timeliness, and access to care identified after the annual reviews.

Table 6: Evaluation of Quality

Strengths Related to Quality
• The 2021/2022 EQR found that four health plans were strong in their processes for tracking and maintaining the development and ongoing review of policies and procedures.

Strengths Related to Quality
• All the health plans demonstrated sufficient staff are in place to ensure health services required by SCDHHS are provided to members. • EQRs found that all health plans have appropriate processes in place for maintenance, updates, and recovery of its data and information systems. • All health plans provide convenient options for reporting actual or suspected fraud, waste, and abuse and are provided in various forums. Trainings and processes were detailed clearly in multiple formats for employees, members, and providers. • Each MCO has a Credentialing Committee that makes credentialing determinations using a peer-review process. • The MCOs have established policies and procedures for suspending or terminating a practitioner for serious quality of care or service issues. • Four of the five MCOs had no issues identified with practitioner credentialing and recredentialing policies and files. • Each of the plans conducts initial provider orientation and ongoing provider education to ensure providers are kept up to date about health plan processes, requirements, provider responsibilities, etc. • Preventive health and clinical practice guidelines are relevant to the MCOs' membership and are adopted from nationally recognized, evidence-based sources. Appropriate processes are established by each of the MCOs for adoption, review, and revision of preventive health guidelines and clinical practice guidelines. • Network providers are educated about the guidelines through routine provider education sessions, Provider Manuals, health plan websites, mailings, and newsletters. • Each plan encourages providers to use the preventive health and clinical practice guidelines and monitors provider compliance through HEDIS monitoring and medical record audits. • Each plan monitors and analyzes data regarding continuity of care, reports to appropriate committees, and uses the data for quality improvement activities and to improve continuity and coordination of care. • Each MCO has processes established to ensure provider compliance with medical record documentation standards. • Results of medical record audits are analyzed, reported to appropriate quality committees, and used for quality improvement activities. • Members are informed of their rights and responsibilities are in welcome materials, handbooks, websites, and newsletters. Members are guaranteed all required rights. • Health plans provide new member information in a variety of ways, including welcome packets, plan websites, newsletters, and Member Handbooks. Members may contact the Member Services call centers and 24-hour nurse lines for additional information and assistance. • The MCOs conduct annual Member Satisfaction Surveys using certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors. • The satisfaction survey results are used to identify quality issues/opportunities for improvement and to implement strategies to address them. Results are reported to the plans' Quality Committees and to network providers. • Healthy Blue's survey validation revealed that response rates for the Adult, Child, and Child with Chronic Conditions improved from the previous year's rates. • Grievance processes and requirements are appropriately documented in policies, member and provider handbooks, and on health plan websites.

Strengths Related to Quality
• The health plans ensure that clinical grievances and grievances related to the denial of expedited appeal resolution are reviewed by a Medical Director or an alternate physician designee. • The health plans track, categorize and analyze grievances for trends, patterns, and opportunities for improvement. Grievance data are routinely reported to appropriate Quality committees. • Grievance files for ATC, Molina, and Select Health, found no identified issues. • Each health plan has developed a QI program description that explains the QI programs' structure, scope, goals, accountabilities, and resources. On an annual basis the QI program descriptions are reviewed and updated as needed. • Four the of five MCOs have performance improvement projects underway aimed at improving the care their members receive. Topics included postpartum care, diabetes, member satisfaction, immunizations, and well-care visits. Additional PIPs are focused on accuracy of encounter data and provider satisfaction. • Across the four MCOs reporting HEDIS rates, 20 measures showed substantial improvement from MY2019 to MY2020. • All the PIPs validated received a score within the "High Confidence" Range. • The UM Program Descriptions are well-written and appropriately describe the goals, scope, and structure of each UM Program. • Each health plan has a medical director that provides oversight for the UM program. • Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-Rater Reliability testing. All the plans expect Humana shared the results of their testing scores. • The analysis of over and under-utilization data was comprehensive and demonstrated a focus on monitoring, evaluating, and addressing utilization issues for four of the health plans. • Plans collecting utilization data showed evidence of monitoring and analysis of data for trending and impacts on appropriate use of services and resources. • Program Descriptions, along with policies and procedures, provide detailed information about each health plan's Case Management, Population Health Management, and/or Care Transitions programs. • The MCOs use information and data from various sources to identify members who may benefit from Care Management services. • Member risk levels are identified and described, and appropriate activities are incorporated into the risk levels. • The health plans have implemented processes to evaluate and assess member satisfaction with Care Management programs. • Each of the health plans execute written agreements with entities to which health plan functions are delegated. • The written agreements outline the functions to be delegated, performance expectations, reporting responsibilities, etc. • The MCOs conduct annual auditing and routine monitoring of delegate performance. • Four of the five MCOs have appropriate processes to monitor and track provider compliance with provision of required immunizations and for conducting required EPSDT services. • Solutions' policies and procedures were found to be reviewed in a timely manner. • All the CICOs had policies and processes established to conduct appropriate transition of care (TOC) functions, as required by the SCDHHS Contract.

Weaknesses Related to Quality	Recommendations Related to Quality
• Humana's policies were not consistently reviewed annually.	• Humana must complete a comprehensive review of policies to reflect a current review cycle.
• Humana's confidentiality policy lacked details for how confidential information is handled.	• Confidentiality policies must include the steps and processes used to safeguard confidential information.
• Humana's Policy (CORE Credentialing and Recredentialing)-001 did not address querying the SCDHHS Termination for Cause List and Policy (Core Sanctions Policy)-002 did not include the SCDHHS SC Provider Terminated for Cause List as a required monthly monitoring element.	• The MCOs should review policies and procedures to ensure all required elements of credentialing/recredentialing and required provider monitoring are addressed.
• Although membership of the plans' credentialing committees includes network practitioners, ATC's committee included only one external network provider (pediatrics). Select Health 's committee did not include any mid-level practitioners and member attendance for several members was below the established attendance requirement.	• The MCOs should work to recruit additional providers for membership of credentialing committees to ensure peer representation, including mid-level practitioners, on the committee. • Ensure member attendance of health plan credentialing committees meets established attendance expectations.
• Humana's credentialing and recredentialing files for practitioners and organizational providers revealed issues related to the dating credentialing approval letters prior to the date of the documented approval of credentialing (a repeat finding from the Readiness Review), failure to collect collaborative agreements for nurse practitioners (a repeat finding from the Readiness Review), failure to query the SCDHHS SC Providers Terminated for Cause List and Excluded Providers Report, failure to query the Social Security Administration's Death Master File.	• Ensure credentialing and recredentialing files include evidence of all required credentialing elements and that provider credentialing/recredentialing determination letters are not dated prior to the determination date.
• Health plan policies define elements that must be included in Provider Directories; however, the policies for all plans failed to include one or more of the required elements.	• Review policies about Provider Directory requirements to ensure all required elements are addressed.
• Policies do not address all contractually mandated appointment access standards (ATC, Healthy Blue, Select Health) and/or include incorrect information (Healthy Blue).	• Review policies to ensure all contractually mandated appointment access standards are addressed, and the information is correct.
• Health plan policies about provider orientation and education contained omissions of information and errors in documentation (Humana and Molina).	• Review and revise policies about provider orientation and ongoing education to ensure the information is complete and correct.
• Humana's Provider Manual contained incorrect information about member benefits.	• Ensure documentation of member benefits is correct in Provider Manuals.
• Issues noted in the MCOs' policies included failure to include all required medical record documentation elements (Select Health), lack of documentation of the frequency of provider medical record audits (Humana), the timeframe for re-audits for providers who do not successfully pass the initial audit and over-read (Molina), and the benchmark score for medical record reviews (Select Health).	• The MCOs should review and revise medical record documentation policies and procedures to ensure all required medical record documentation elements are addressed. The policies should clearly reflect the processes for evaluating provider compliance, including frequency of audits, timeframes for follow-up of providers who do not pass the initial audit, and benchmark scores.

Weaknesses Related to Quality	Recommendations Related to Quality
• Select Health's 2021 Annual Assessment of State Audits for Medical Record Documentation report indicated not all required medical record documentation elements were included.	• When conducting medical record audits, ensure all required elements are being evaluated.
• Member Satisfaction Survey response rates decreased for ATC, Molina, and Select Health. Of note, ATC's rates have decreased for the last three review cycles.	• Conduct barrier analyses to determine the issues with obtaining survey responses. Evaluate for additional methods to improve response rates, such as cover letter design, mode and timing of administration, and member awareness campaigns. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.
• For Healthy Blue, grievance files reflected that the plan does not always follow its own policy regarding the timeframe for acknowledging grievances. Humana's grievance files revealed issues with the timeliness for sending acknowledgement letters, untimely grievance resolution, and not taking appropriate action to resolve a member's request for a list of PCPs in her area.	• Review processes and timeliness standards for grievances and implement steps for performance improvement.
• Humana's Quality Assurance Committee did not include a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*.	• Health plans should recruit a variety of participating network providers to serve as members of the Quality Committee(s).
• Across the four MCO reporting HEDIS rates, 19 measures showed substantial decline from MY2019 to MY2020.	• Monitoring interim administrative rates, when available, for HEDIS measures that have declined in the past year's trending analysis to determine if trend is consistent and in need of intervention.
• Humana did not have any performance improvement projects planned or underway.	• Humana should continue the review of baseline data and convene work groups so topics for performance improvement projects can be developed.
• Molina's QI Program Evaluation did not include the analysis, results, and interventions for the availability of practitioners, the continuity and coordination of care, and the provider directory analysis.	• When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.
• Humana had not conducted IRR testing despite a policy indicating that associates with at least three months tenure are expected to complete IRR testing.	• Ensure Utilization management standards/criteria are consistently applied to all members across all reviewers.
• Humana provided one appeal file. The resolution notice did not indicate the decision to uphold the original denial was made by a physician and the language used to describe why the denial was upheld appeared to be above the 6th-grade reading level.	• Develop a process for monitoring resolution notices to ensure the letter contains correct reviewer information and the language meets the SCDHHS 6th-grade reading level.
• Minor issues were noted in documentation in program descriptions, policies, and procedures related to Targeted Case Management Services (ATC), program structure, (Humana), and	• Ensure Care Management program descriptions, policies, and/or procedures thoroughly document program processes and requirements.

Weaknesses Related to Quality	Recommendations Related to Quality
requirements for assessment and outreach (Molina).	
• Overall, CM files reflected appropriate activities are conducted and established processes are followed. One ATC file, however, revealed a member concern was not addressed in care planning activities.	• Ensure all member concerns are addressed in care plans.
• Humana did not have a specific policy or action steps planned for addressing the process for how the monitoring of over and under-utilization will be conducted. This was an issue identified during the Readiness Review.	• Provide more detail in the Utilization Management Data Plan regarding issues identified during the monitoring of over or under-utilization. The data plan should include steps If monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.
• ER visits and readmissions remain an area of opportunity for utilization monitoring and intervention.	• Establish work groups to identify opportunities for improving ER visit and readmission rates.
• Issues regarding annual oversight of delegated entities included untimely completion of annual oversight (ATC) and failure to monitor delegates for all required credentialing elements (Healthy Blue).	• Ensure annual oversight activities are completed in a timely manner and that credentialing/ recredentialing delegates are monitored for all required credentialing and recredentialing elements.
• Humana did not have a policy or procedure for monitoring provider compliance with administering immunizations and performing EPSDT or well-care services for members and provided no evidence that it is currently monitoring or tracking this information.	• Humana should develop and implement a policy/procedure for monitoring provider compliance with immunization administration and EPSDT/well-care services. Results of the monitoring should be reported to appropriate committees and used for quality improvement activities.
• Four out of the five MCOs were noted to have uncorrected deficiencies from the previous year's reviews.	• Ensure that Quality Improvement Plans from EQRs are addressed and that action is implemented to correct all identified deficiencies.
• Solutions' personnel files lacked evidence of the monthly exclusion screenings.	• Review processes needed to ensure that steps are taken to complete monthly exclusion monitoring.
• Solutions' project documents lacked details regarding the selected study question and aim for the projects. Clearly defined measurable indicators, the baseline measurement, specific goal(s), the method for data collection, identified barriers and interventions to address those barriers was also not included.	• Revise the project documents to address the missing information.
• Solutions was not conducting ongoing provider education.	• Consider conducting ongoing provider education using alternate forums such as webinars, virtual meetings, etc.
• Solutions' policies did not address discharge planning for hospitalized participants and did not provide complete information about reporting suspected abuse, neglect, or exploitation of a participant.	• Ensure policies completely address required activities.

Weaknesses Related to Quality	Recommendations Related to Quality
• Some forms in Solutions' participant files were not dated.	• Ensure all documentation in participant files is dated.
• ATC and Molina continue to have transition of care issues for the Medicare/Medicaid population. Files lacked documentation of the required follow-up assessments, reassessments, PCP notifications, and collaboration with facility Case Management or Discharge Planning staff.	• Ensure all TOC functions required by the *SCDHHS Contract, Sections 2.5* and *2.6* are conducted and clearly documented in the members' files.
• For ATC, transitions that result in a move to a higher level of care are not analyzed to determine factors that contributed to the change and actions needed to improve outcomes.	• CICOs should collect and analyze the data for transitions that result in a higher level of care to identify contributing factors and improvement opportunities.

Table 7: Evaluation of Timeliness

Strengths Related to Timeliness
• Timeliness guidelines for processing appeals met the contract and federal requirements for all MCOs.

Weaknesses Related to Timeliness	Recommendations Related to Timeliness
• Humana's policy incorrectly listed the timeframe for completing a non-expedited review and did not include the 14-day extension requirements or the timeframe for completing a request for Substance Abuse treatments.	• Humana should correct the errors noted in their policy related to timeliness for UM decisions.
• The negative PDL changes were not published on the health plans' website at least 30 days prior to implementation as required by the *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3*. The changes posted by ATC, Healthy Blue, Humana, and Molina did not meet this requirement.	• Members and providers should be notified of negative PDL changes by posting the change on the health plans' website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3*.
• Humana's Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation for when to use this contact information.	• Humana should correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.
• Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process.	• Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy, SCDHHS Contract, and federal regulations. Implement interventions to address the barriers.
• Molina had three appeal files there were untimely and four files where the physician who made the appeal determination was not of the same or similar specialty as the ordering physician.	• For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate physician reviewers regarding only utilizing review criteria and not considering individual medical conditions when making appeal determinations.

Table 8: Evaluation of Access to Care

Strengths Related to Access to Care
• The MCOs have defined geographic access standards for primary care and specialty providers and established processes to routinely monitor and assess provider network adequacy. • The health plans monitor and evaluate their networks' abilities to serve members with special needs and provide information about cultural competency in Provider Manuals and on websites. • The MCOs maintain online provider directories and either published or "on-demand" print provider directories. • The MCOs routinely monitor provider compliance with appointment access standards. • Plans have continued to introduce and revise data-driven processes and methods to update provider contact information. • Appropriate processes are in place to notify members of changes in benefits and provider networks. • The MCOs ensure member materials are written at appropriate grade levels for understanding and are available in alternate formats. • The MCOs inform members of available preventive care programs, disease management programs, and wellness incentives. • Members are encouraged to utilize preventive care services through call/text campaigns, flyers, newsletters, websites, call center staff, etc. • Each health plans use nationally recognized screening criteria for their services authorization requests. • UM files reflected use of appropriate criteria and appropriate attempts to obtain additional information when needed. • All of the MCOs provide required core benefits to members. • The CICOs maintained a network sufficient to provide enrollees with access to a full range of Home and Community Based Services in each geographic area.

Weaknesses Related to Access to Care	Recommendations Related to Access to Care
• Select Health noted 15 vacant positions in the Customer Service area on the Organizational Chart.	• Select Health must monitor the current back-up plan to ensure that Customer Service responsibilities are met and review the recruitment process for the 15 vacant positions.
• ATC's Geo Access mapping from November 2021 did not include results for all SCDHHS-designated Status 1 provider types. This was a repeat finding from the previous EQR.	• Ensure Geo Access mapping and other network evaluations include all required Status 1 provider types.
• Molina's printed Provider Directory did not include practitioner website addresses.	• Ensure Provider Directories include all required elements.
• For the Telephonic Provider Access Studies conducted by CCME, three of five MCOs did not show improvement from the previous study's results.	• Update provider enrollment files on a timely basis to reflect active providers that are accepting the health plan. • Develop and implement processes to improve accuracy of provider contact information, status, and location. • Determine additional methods to maintain updated provider status in provider files.

Weaknesses Related to Access to Care	Recommendations Related to Access to Care
• Humana's Member Handbook did not include full benefit information for chiropractic services, communicable disease services, newborn hearing screenings, rehabilitative therapies for children, BabyNet Services, and transplant services.	• Ensure member materials include complete information about benefits to which members are entitled.
• Molina requires the member to follow-up an appeal received verbally with a written request even though this requirement was removed from the SCDHHS Contract and the Federal Regulation.	• Revise all documents related to the process for filing an appeal and remove the requirement that indicates a standard request for an appeal received verbally must be followed by a written request.

BACKGROUND

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

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

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

After completing the annual review of the required EQR activities, CCME submits a detailed technical report to SCDHHS and the health plan. This report describes the data aggregation and analysis, as well as the manner in which conclusions were drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths, weaknesses, recommendations for improvement, and the degree to which the plans addressed quality improvement recommendations made during the prior year's review. Annually, CCME prepares a comprehensive technical report for the State which is a compilation of the individual annual review findings. The comprehensive technical report for contract year 2021 through 2022 contains data for: ATC, Healthy Blue, Humana, Molina, Select Health, and Solutions. The report also includes EQR findings for the plans participating in the Healthy Connections Prime Program under review during this reporting period.

METHODOLOGY

The process used by CCME for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to each plan's office. After completing the annual review, CCME submits a detailed technical report to SCDHHS and the health plan (covered in the preceding section titled, *Background*). For a health plan not meeting requirements, CCME requires the plan to submit a quality improvement plan for each standard identified as not fully met. CCME provides technical assistance to each health plan until all deficiencies are corrected.

During this contract year, all onsite visits were conducted virtually due to restrictions from the COVID-19 pandemic.

The following table displays the dates of the EQRs conducted for each health plan.

Table 9: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Reports Submitted
ATC ATC MMP	11/29/21	1/26/22 - 1/27/22	2/24/22
Healthy Blue	3/14/22	5/11/22 - 5/12/22	6/9/22
Humana	1/10/22	3/2/22 - 3/3/22	3/31/22
Molina Molina MMP	2/14/22	4/6/22 - 4/7/22	5/5/22
Solutions	5/30/22	8/3/22	8/22/22
Select Health	9/13/21	11/17/21 - 11/18/21	12/17/21

FINDINGS

The plans were evaluated using the standards developed by CCME and summarized in the tables for each of the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate that there was no change in the score from the previous review.

A. Administration

42 CFR § 438.242, 42 CFR § 457.1233 (d), 42 CFR § 438.224

CCME found policies and procedures in place for each of the five health plans, which represents a strength in ensuring quality care is provided to members. However, the review of Humana's policies and procedures did not find documentation of consistent monitoring and revision completed on an annual basis.

Table 10 outlines the findings related to policy management from Humana's 2021 Readiness Review and Humana's response to the findings. As noted, Humana's review of policy and procedure titling and formatting is ongoing.

Table 10: Humana's Previous EQR Deficiencies and Quality Improvement Response

Standard	EQR Comments
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.	Humana has in place written policies and procedures that state its commitment to demonstrate compliance with applicable federal and state standards. Many of the policies contained language directly copied from the *SCDHHS Contract* but did not specifically indicate Humana's process for meeting the requirements. Many of the policies contained information related to Medicare or to other lines of business not specific to South Carolina. Policies are not consistent in the way they are titled and formatted. *Quality Improvement Plan: Complete a comprehensive review of policies and procedures and add Humana's processes to accurately reflect steps currently in place or that need to be in place to demonstrate Contract compliance.*
Humana Response: Humana reviewed policies and procedures to identify all documents that require updates in order to address the Readiness Quality Improvement Plan Review comments. Humana is currently updating identified documents to include the process for meeting the contractual requirements, specific to South Carolina Medicaid. Humana's plan and timeline for addressing the Review comments is as following: •Comprehensive review of policies and procedures – [COMPLETE] •Update policies and procedures to accurately reflect process (first draft) -June 10, 2021 •Finalize updated policies and procedures – July 1, 2021 •Comprehensive review of policy and procedure titling and formatting – ongoing	

The organizational structure and business management processes were reviewed for each MCO. It was noted for ATC and Healthy Blue that sufficient staff are in place to ensure services required by SCDHHS are provided to members. Select Health confirmed during onsite discussion that recruiting efforts are underway to fill 15 vacant positions in the Customer Services area. Onsite discussion for Molina addressed changes needed for the Organizational Chart since the date of the EQR submission to CCME. There was discussion regarding current vacant positions and the process for filling identified positions. Job functions of backfilled positions were discussed while the recruiting process is completed.

For Humana, it was noted that previously identified vacant positions had been filled. The Organizational Chart demonstrates there is sufficient staff available to meet contract requirements. Table 11 lists issues related to staffing identified in Humana's Readiness Review. These issues have been corrected.

Table 11: Humana's Previous EQR Deficiencies and Quality Improvement Plans

Standard	EQR Comments
I B. Organizational Chart / Staffing	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: 1.5.2 Utilization Review Staff	It was reported during the onsite discussion that Humana was currently recruiting UM staff. The expected ratio will be one nurse per15,000 members. *Quality Improvement Plan: Continue the recruitment efforts for clinical staff responsible for conducting utilization management functions.*
Humana Response: Lindsay Johnson, LCSW, and Karen Wisniewski, BSN, joined the Humana Healthy Horizons in South Carolina team on May 24th as our Behavioral Health and Physical Health Utilization Management team.	
1.5.3 *Case Management Staff	Humana is currently recruiting Case Management staff for SC. The Case Manager staffing ratio will be one case manager per 5,000 members. *Quality Improvement Plan: Develop a plan to ensure staff are hired in South Carolina and orientation completed before members are enrolled.*
Humana Response: LaToya Blackmon, LCWS, and Dana Eisenberg, RN, joined the Humana Healthy Horizons in South Carolina team on May 24th as our Behavioral Health and Physical Health Case Management team and their orientation will be completed prior to member enrollment.	
1.6 *Quality Improvement (Coordinator, Manager, Director);	The Quality Improvement Manager position is currently vacant. Humana's Medical Director will assume these responsibilities until the Plan reaches 90k members. However, an offer is pending for the Medical Director during time of onsite. *Quality Improvement Plan: Develop a plan to hire a Medical Director to cover the Quality Improvement activities until a SC Quality Improvement Manager can be hired.*
Humana Response: Dr. Ayo Gathing will start with Humana on June 1st as the Humana Healthy Horizons in South Carolina Medical Director. Dr. Gathing will assume the role of the Quality Improvement Manager until the plan reaches 90,000 members.	
1.6.1 Quality Assessment and Performance Improvement Staff	It was reported during the onsite discussion that QM staff are being recruited. The staffing ratio for the QM staff is expected at 1:45,000. *Quality Improvement Plan: Develop a recruitment plan to ensure staff are in-place to meet the expected staffing ratio.*
Humana Response: Humana has posted its Quality Improvement position for Humana Healthy Horizons in South Carolina and is expecting to fill the role within 60-90 days.	
1.8 *Member Services Manager	Joe Piemonte is the Member Services Manager located in Florida. However, this position is required to be in South Carolina. *Quality Improvement Plan: Recruit a Member Services Manager that will be located in SC.*

Standard	EQR Comments
Humana Response: Taffney Hooks, Member Services Manager and South Carolina resident, started with Humana Healthy Horizons in South Carolina on May 17th.	
1.9 *Medical Director	It was reported during the onsite discussion that Humana is currently recruiting, with an offer pending for a Medical Director. *Quality Improvement Plan: Develop a plan to ensure this position is filled before members are enrolled.*
Humana Response: Dr. Ayo Gathing will start with Humana Healthy Horizons in South Carolina on June 1st as our Medical Director. 6/8/21—At Humana we pride ourselves on having a Clinically Integrated Model of Care. This entails the provision of seamless, effective and efficient care that reflects the whole of a person's health needs: from prevention through treatment, across both physical and behavioral health, taking into consideration social determinants of health, and in partnership with the individual, their physician, family and community. Dr. Ayo Gathing is our SC Chief Medical Officer. She is a Board-Certified Psychiatrist with years of experience as a Medical Director. She supervises our Clinical Team comprised of a Health Services Director, UM/CM BH Clinicians, UM/CM Nurses, and a Transition Coordinator. Dr. Gathing will conduct our initial PA reviews in the market. We also have internal, Shared Services MD's licensed in SC that are available for consultation with Dr. Ayo, across multiple specialties. If necessary, we are also contracted with 2 vendors, FOCUS and NMR (Network Medical Review) who also have MD's licensed in SC across multiple specialties to support Dr. Gathing.	
1.13 Board Certified Psychiatrist or Psychologist	It was reported during the onsite discussion that this position is not currently filled, recruitment is underway. *Quality Improvement Plan: Develop a plan to ensure this position is filled before members are enrolled.*
Humana Response: Dr. Ayo Gathing will start with Humana Healthy Horizons in South Carolina on June 1st as our board-certified psychiatrist.	

Each MCO submitted policies and procedures, training documents, and a Compliance Plan demonstrating processes to educate employees, subcontractors, members, and providers about reporting options, roles, and rights specific to fraud, waste, and abuse. Processes for identifying, preventing, investigating, and taking corrective action against any provider or member who is suspected of participating in FWA activities were outlined. Internal monitoring, auditing, and investigations are conducted to identify existing or potential compliance risks. Written policies, procedures, and standards of conduct were reviewed and are made available to employees at the time of employment and annually, thereafter.

Health plan Compliance Committees meet quarterly and have been established to monitor risks and review data reported to ensure adherence to policies and procedures. Compliance Officers are identified in the MCO Organizational Charts. Each Compliance Committee Charter outlines member roles and responsibilities. Voting and non-voting members are identified in meeting minutes, and the minutes reflect activities and committee actions toward the mission of the committee. The health plans monitor and

conduct periodic audits to ensure adherence to written policies, procedures, and evaluation of compliance with regulatory standards.

The review of desk materials for each MCO found that policies, procedures, and training materials are in place for employees and providers outlining expectations of compliance with all applicable laws with respect to uses and disclosures of PHI.

Information Systems Capabilities Assessment

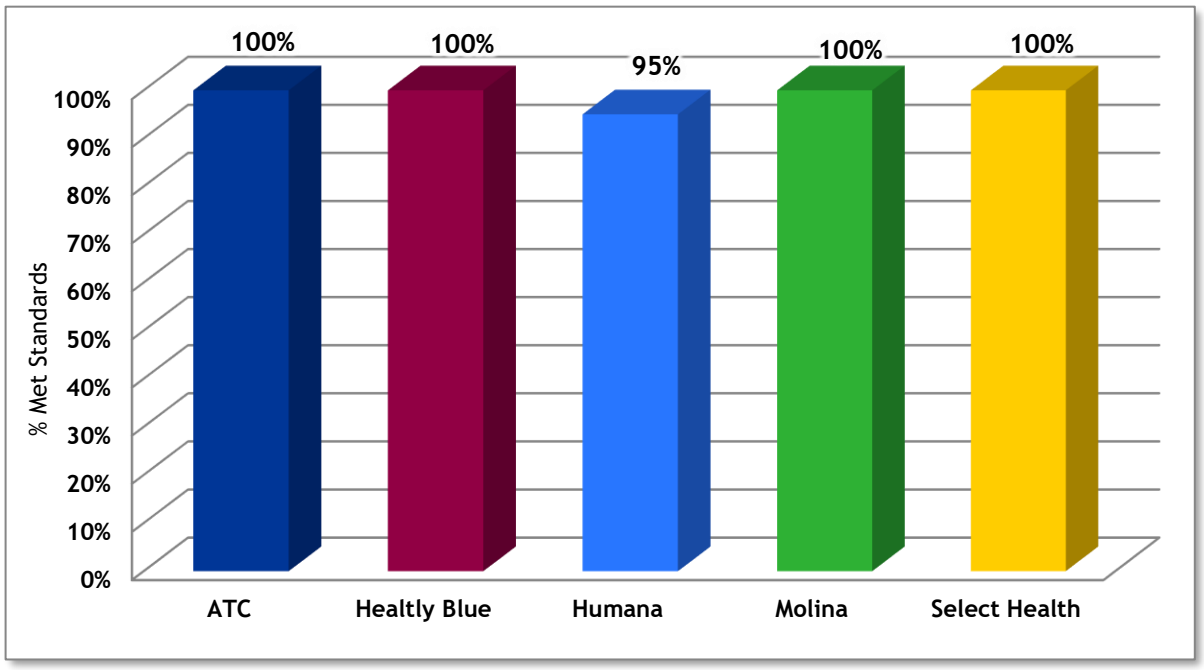
42 CFR § 438.242, 42 CFR § 457.1233 (d)

Information Systems Capabilities Assessment (ISCA) documentation indicates each MCO's systems, processes, and polices satisfy requirements of the *SCDHHS Contract*. ATC's system security plan notes that a monitoring system, which allows ATC to verify that information systems comply with federal, state, contractual requirements, has been implemented. Recent disaster recovery tests demonstrated that ATC's information systems can be fully recovered from a serious disaster. Select Health's data retention policy provides staff with an easy-to-understand retention schedule for the various documents they may handle. Molina performs actual disaster recovery testing (as opposed to tabletop testing), and the most recent test proved that systems could be recovered in accordance with the organization's objectives. Disaster Recovery Plans were found to be comprehensive and tested on a scheduled basis. Data reporting is updated monthly and MCOs review and analyze data to ensure reasonableness.

Healthy Blue's claims benchmark requires the organization to pay 98% of claims within 30 days, and 99% of claims within 90 days. This benchmark exceeds the State's requirement and is reflected in the organization's measured average claim payment times. Systems can accept and generate HIPAA-compliant electronic transactions. It was specifically noted in the health plan's documentation that the organization uses industry standard formats for its electronic and paper claims.

As noted in *Figure 2: Administration*, 100% of the standards were scored as "Met" for four of the South Carolina health plans reviewed during the 2021/2022 EQR review period. Humana received scores of "Met" for 95% of the Administration standards.

Figure 2: Administration



An overview of the scores for the Administration section is illustrated in *Table 12: Administration Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 12: Administration Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
General Approach to Policies and Procedures						
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Partially Met	Met	Met	**Strengths:** ▶ The 2021/2022 EQR found that four health plans were strong in their processes for tracking and maintaining the development and ongoing review of policies and procedures. **Weaknesses:** ▶ Humana's policies were not consistently reviewed annually. **Recommendations:** • Humana must complete a comprehensive review of policies to reflect a current review cycle.
Organizational Chart / Staffing						
The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: *Administrator (CEO, COO, Executive Director)	Met	Met	Met	Met	Met	**Strengths:** ▶ All the health plans demonstrated sufficient staff are in place to ensure health services required by SCDHHS are provided to members. **Weaknesses:** ▶ Select Health noted 15 vacant positions in the Customer Service area on the Organizational Chart.
Chief Financial Officer (CFO)	Met	Met	Met	Met	Met	
*Contract Account Manager	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Information Systems personnel Claims and Encounter Manager/ Administrator	Met	Met	Met	Met	Met	**Recommendations:** • Select Health must monitor the current back-up plan to ensure that Customer Service responsibilities are met and review the recruitment process for the 15 vacant positions.
Network Management Claims and Encounter Processing Staff	Met	Met	Met	Met	Met	
Utilization Management (Coordinator, Manager, Director)	Met	Met	Met	Met	Met	
Pharmacy Director	Met	Met	Met	Met	Met	
Utilization Review Staff	Met	Met	Met ↑	Met	Met	
*Case Management Staff	Met	Met	Met ↑	Met	Met	
*Quality Improvement (Coordinator, Manager, Director)	Met	Met	Met ↑	Met	Met	
Quality Assessment and Performance Improvement Staff	Met	Met	Met ↑	Met	Met	
*Provider Services Manager	Met	Met	Met	Met	Met	
*Provider Services Staff	Met	Met	Met	Met	Met	
*Member Services Manager	Met	Met	Met ↑	Met	Met	
Member Services Staff	Met	Met	Met	Met	Met	
*Medical Director	Met	Met	Met ↑	Met	Met	
*Compliance Officer	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Program Integrity Coordinator	Met	Met	Met	Met	Met	
Compliance /Program Integrity Staff	Met	Met	Met	Met	Met	
*Interagency Liaison	Met	Met	Met	Met	Met	
Legal Staff	Met	Met	Met	Met	Met	
Board Certified Psychiatrist or Psychologist	Met	Met	Met ↑	Met	Met	
Post-payment Review Staff	Met	Met	Met	Met	Met	
Operational relationships of MCO staff are clearly delineated	Met	Met	Met	Met	Met	
Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
The MCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met	**Strengths:** ▶ The 2021/2022 EQR found that all health plans have appropriate processes in place for maintenance, updates, and recovery of its data and information systems.
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	Met	Met	Met	Met	
The MCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met	
The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met	
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met	Met	Met	Met	Met	
The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented	Met	Met	Met	Met	Met	
Compliance/Program Integrity						
The MCO has a Compliance Plan to guard against fraud and abuse	Met	Met	Met	Met	Met	**Strengths:** ▶ The 2021/2022 EQR found that all health plans provide convenient options for reporting actual or suspected fraud, waste, and abuse are provided in various forums. Trainings and processes were detailed clearly in multiple formats for employees, members, and providers.
The Compliance Plan and/or policies and procedures address all requirements	Met	Met	Met	Met	Met	
The MCO has an established committee responsible for oversight of the Compliance Program	Met	Met	Met	Met	Met	
The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse	Met	Met	Met	Met	Met	
The MCO's policies and procedures define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met	
The MCO has processes in place for provider payment suspensions and recoupments of overpayments	Met	Met	Met	Met	Met	
The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Met	Met	Met	Met	Met	
Confidentiality *42 CFR § 438.224*						

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Partially Met ↓	Met	Met	**Weaknesses:** ▶ Humana's confidentiality policy lacked details for how confidential information is handled. **Recommendations:** • Confidentiality policies must include the steps and processes used to safeguard confidential information.

B. Provider Services

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

Included in the review of Provider Services are policies and procedures, credentialing and recredentialing processes and files, adequacy and accessibility of provider networks, processes for provider education, processes for assessing provider medical record documentation, and preventive health and clinical practice guidelines.

Credentialing and Recredentialing

42 CFR § 438.214, 42 CFR § 457.1233(a)

The MCOs have established committees that use a peer-review process to render credentialing determinations. The committees have defined meeting frequencies, established membership, and are chaired by the plan Medical Directors/Chief Medical Officers. The plans include network providers with various specialties in the membership of the committees. Recommendations were given to the MCOs to address identified findings, including:

- ATC's Credentialing Committee policy (Policy CC.CRED.03) did not address the attendance expectations for committee members and the Credentialing Committee Roster contained outdated membership information. As recommended by CCME during the previous EQR, ATC successfully recruited an additional adult medicine provider for committee membership. However, due to the low number of network practitioners, CCME again recommended that ATC attempt to recruit additional network physicians for committee membership to ensure broad representation from all disciplines within the network.
- As a result of a Quality Improvement Plan from the previous review, Humana's Medicaid Credentials Committee began operations in December 2021. Attendance documentation for the December 2021 committee meeting incorrectly listed two internal staff member attendees as voting members and the header of the document stated, "Louisville Credentials Committee Agenda."
- Select Health's Credentialing Committee Charter defined member attendance expectations. Committee minutes indicated two members did not meet the attendance expectation. Select Health staff reported that designees may have attended the meeting in place of the absent practitioners; however, this was not apparent in the attendance documentation in the minutes.

Each of the MCOs has policies and procedures that describe processes and requirements for initial and ongoing provider credentialing. For a Healthy Blue policy, CCME noted discrepancies regarding provider appeals of credentialing determinations. Humana's

policies did not address the requirement for querying the SCDHHS Termination for Cause List. The previous EQR of Humana found that policies did not address the contractual requirement to report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery. The most recent EQR confirmed Humana corrected this finding.

For the current EQR, a sample of provider credentialing and recredentialing files was reviewed for each MCO.

No major issues were noted in the credentialing and recredentialing files for ATC; however, one file was missing verification of the provider's National Provider Identifier. A recommendation was offered to ensure initial credentialing files for all providers include evidence of verification of the provider's National Provider Identifier.

No issues were noted in the credentialing and recredentialing files for Healthy Blue. For the previous EQR, Healthy Blue had issues related to verification of CLIA Certificates (or Certificate of Waiver) for providers billing laboratory procedures. The current EQR confirmed this issue was resolved. See *Table 13: Healthy Blue Previous EQR Provider Credentialing and Selection QIP Items*.

Table 13: Healthy Blue Previous EQR Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
3.1 Verification of information on the applicant, including: 3.1.15 CLIA Certificate (or certificate of waiver) for providers billing laboratory procedures;	Three of the 14 initial credentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area. *Quality Improvement Plan: Revise credentialing processes to include evidence of CLIA certificates for all applicable practice locations in the credentialing files.*
Healthy Blue's Response: The credentialing application has been updated to include the capture of CLIA certification numbers for all of a provider's practice locations (No. 9 on attached application). A policy has been implemented (draft attached) that describes the process to be utilized to assure staff collect the CLIA certificate numbers and verify the CLIA certificates for each provider practice location. Provider educational materials will include information on inclusion of CLIA certificate numbers for all practice locations on the application. Monthly provider newsletter will inform providers of the requirement for them to enter the CLIA certificate number for all practice locations on the application. The application check list used by the credentialing specialists includes the validation of CLIA certificates for all practice locations and to include those verifications in each application packet for the providers to which this applies.	
4.2 Verification of information on the applicant, including:	Three of the 18 recredentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing

Standard	EQR Comments
4.2.14 CLIA Certificate for providers billing laboratory procedures;	staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area. *Quality Improvement Plan: Revise recredentialing processes to include evidence of CLIA certificates for all applicable practice locations in the recredentialing files.*
Healthy Blue's Response: The re-credentialing application has been updated to include the capture of CLIA certification numbers for all of a provider's practice locations. A policy has been implemented (draft attached) that describes the process to be utilized to assure staff collect the CLIA certificate numbers and verify the CLIA certificates for each provider practice location. Provider educational materials will include information on inclusion of CLIA certificate numbers for all provider practice locations on the application. Monthly provider newsletter will inform providers of the requirement for them to enter the CLIA certificate number for all practice locations on the application. The application check list used by the credentialing specialists includes the validation of CLIA certificates for all practice locations and to include those verifications in each application packet for the providers to which this applies.	

No major issues were noted in the credentialing and recredentialing files for Molina and Select Health. For Molina, a recommendation was offered to reach out to organizational providers and/or conduct independent verification of CLIA certification status when the credentialing application is incomplete regarding laboratory services and/or CLIA certification. For the previous EQR, Select Health had issues related to queries of the Social Security Death Master File and verification of CLIA Certificates (or Certificate of Waiver) for providers billing laboratory procedures. The current EQR confirmed this issue was resolved. See *Table 14: Select Health Previous EQR Provider Credentialing and Selection QIP Items*.

Table 14: Select Health Previous EQR Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
3.1 Verification of information on the applicant, including: 3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	One initial credentialing file was missing evidence of query of the Social Security Administration's Death Master File. Three additional initial credentialing files did not contain clear evidence that the query of the Social Security Administration's Death Master File was conducted against the provider's Social Security Number. *Quality Improvement Plan: Ensure all initial credentialing files contain evidence of querying the Social Security Administration's Death Master File and that the evidence clearly indicates the provider's Social Security Number was used for the query.*
Select's Response: The Credentialing Department received additional education on proper verification of SSDMF results by Social Security Number through Provider Trust. Associates will search the databases utilizing the providers Social Security Number and the results will be saved as a PDF in the provider's credentialing file. Please see updated Credentialing Team Training Bulletin-Provider Trust implemented in October 2020 for	

Standard	EQR Comments
the Credentialing Team. As part of its monitoring and auditing plans, the health plan will complete a review of a sample of files on an ongoing basis to verify this process continues to be performed.	
4.2 Verification of information on the applicant, including: 4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	Policy CR.100.SC, Health Care Professional Credentialing and Re-credentialing, states Primary Source Verification (PSV) is completed on the Clinical Laboratory Improvement Amendment (CLIA) for any practitioner who has lab services in an office where they are treating members and who does not submit a current copy of the CLIA. The policy further states, "All verifications, with the exception of education/training and work history may not be older than 120 calendar days at the time of the credentialing or re-credentialing decision." Of 16 recredentialing files reviewed, 9 files revealed issues with primary source verification (PSV) of the providers' CLIA Certificates or Certificates of Waiver. The following issues were noted in these 9 files (note: some files contained more than one location for which CLIA would apply): •In two files, there was no evidence of PSV of the CLIA. •In two files, the PSV of the CLIA occurred after the recredentialing decision date. •In six files, the PSV of the CLIA occurred more than 120 days prior to the recredentialing decision date. (Note: one was more than 12 months prior, and another was 21 months prior.) •In one file, the PSV of the CLIA was for a different address. *Quality Improvement Plan: Ensure primary source verification of CLIA Certificates or Certificates of Waiver are included in each recredentialing file, are conducted within the timeframe specified in Policy CR.100.SC, Health Care Professional Credentialing and Re-credentialing, and are for the correct location.*
Select's Response: CLIA Primary Source Verifications will be completed for all credentialing and re-credentialing applications following the timeframes specified in policy CR.100.SC. The CLIA verification process has been updated to be in line with the CMS website updates. Additional education was provided to staff. Please see CLIA Bulletin and CLIA Process. As part of its monitoring and auditing plans, the health plan will complete a review of a sample of files on an ongoing basis to verify this process is being performed in accordance with CR.100.SC.	

A significant number of issues were identified in the files for Humana, including:

- For 28 of 32 practitioner credentialing and recredentialing files reviewed, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This was a repeat finding from the 2021 Readiness Review.
- For 24 of 28 organizational provider credentialing and recredentialing files reviewed, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This was a repeat finding from the 2021 Readiness Review.

- All of the credentialing and recredentialing files for nurse practitioners reviewed were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*. This was a repeat finding from the 2021 Readiness Review.
- One of the 28 organizational provider credentialing and recredentialing files reflected untimely verification of the SCDHHS Excluded Provider's Report (conducted three months after the determination date).
- None of the 32 practitioner credentialing and recredentialing provider files included evidence of querying the SCDHHS SC Providers Terminated for Cause List.
- None of the 28 organizational provider credentialing and recredentialing files included evidence of querying the SCDHHS Providers Terminated for Cause List.
- Ten of 32 practitioner credentialing and recredentialing files reviewed did not include evidence of querying the Social Security Administration's Death Master File.

As noted above, Humana did not adequately address the credentialing and recredentialing file findings from the previous review. *Table 15: Humana Previous EQR Provider Credentialing and Selection QIP Items* describes the issues noted during Humana's previous review and the plan's response to those findings.

Table 15: Humana Previous Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	CCME could not identify a policy or other document that addressed requirements from the *SCDHHS Contract, Section 11.12.11.7* to report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery. Onsite discussion revealed Humana takes action within 48 hours to terminate the provider and immediately notifies SCDHHS. *Quality Improvement Plan: Revise an appropriate policy to define the process Humana will follow for report to SCDHHS any network providers that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.*
Humana Response: Humana revised its CORE Credentialing & Recredentialing Policy to define the process addressed in the Readiness Quality Improvement Plan comments for Line Item 9. Please refer to the following: • HUM4200-11132020 – Policy (CORE Credentialing and Recredentialing) – 001	
2. Decisions regarding credentialing and recredentialing are made by a	Humana does not have a local Credentialing Committee. Instead, Humana's Corporate Credentials Committee reviews and makes the

Standard	EQR Comments
committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	final credentialing determination for each market/plan. Humana confirmed during the onsite that there is no representation from South Carolina on this corporate committee. However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8* requires the following: •"Each MCO will maintain a Credentialing Committee." •"The MCO's Medical Director shall have overall responsibility for the committee's activities." •"The committee shall have a broad representation from all disciplines (including mid-level practitioners) and reflect a peer review process." *Quality Improvement Plan: Establish a local (plan level) Credentialing Committee to make credentialing determinations for the South Carolina Medicaid provider network. Ensure the MCO Medical Director oversees and has overall responsibility for the committee's activities. Ensure the committee includes network provider representation from various specialties, including mid-level practitioners. A committee charter should be developed to specify the committee's roles and responsibilities, membership, meeting frequency, quorum, attendance requirements, etc. The corporate Credentials Committee may make initial credentialing determinations, but the ultimate approval of all South Carolina Medicaid network providers is the responsibility of the plan-level Credentialing Committee.*
Humana Response: Humana is actively in the process of standing up a local South Carolina Medicaid Credentials Committee, with a planned go-live date of July 2021. The South Carolina Medicaid Credentials Committee will be overseen by a South Carolina Humana Chief Medical Officer (CMO) and will be responsible for making determinations for all credentialing and recredentialing decisions. The South Carolina Medicaid Credentials Committee will meet monthly and will be comprised of participating providers from various specialties, including mid-level practitioners. Evidence of South Carolina Medicaid Credentials Committee discussion and decisions will be documented in meeting minutes and certified by the chairperson or designee by means of signature. Please refer to the following: •HM4200 -07012021 - Program Description (Credentialing Program Specific Description) •HM4200 -07012021 - Policy (Credentials Committee Program Specific Charter) ○HM4200 -07012021-Policy (2021 Humana SC MCD QAPI Program Description)-012at pages 18-19, 26.	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	Policy (CORE Credentialing and Recredentialing)-001 states, "Humana shall credential and recredential contracted providers in accordance with NCQA credentialing and recredentialing standards as outlined in the Corporate Credentialing and Recredentialing Policy and the South Carolina's Department of Health and Human Services (SCDHHS) contract." NCQA HP Standards and Guidelines, CR 1: Credentialing Policies, Element A: Practitioner Credentialing Guidelines, Factor 8: Notification of decisions requires the health plan to notify applicants of initial credentialing decisions and recredentialing denials no later

Standard	EQR Comments
	than 60 calendar days from the Credentialing Committee's decision. For all independent practitioner credentialing files reviewed, the date on the approval notification letter was prior to the date of the Credentialing Committee's decision to approve the provider. Humana stated during onsite discussion that once the Medical Director approves Category I (or "clean") credentialing files, the approval letter is sent to the practitioner. CCME requested on two occasions the dates of Medical Director approval for the reviewed files. This information was not provided. *Quality Improvement Plan: Ensure independent practitioner credentialing files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.* Of two nurse practitioner files submitted for review, only one included the formal collaborative agreement between the nurse practitioner and the supervising physician. Humana staff responded to this issue with the following statements: •"Provider is not staffed at a nurse practitioner only facility." •"Provider South Carolina Nurse Practitioner license says Supervised by Daniel Robert Conner (MDO)." •"Provider South Carolina Nurse Practitioner license was verified 12/16/2020." However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8* "Requirements for the Utilization of Nurse Practitioners (NPs) as Providers of Health Care Services" states MCOs must confirm the nurse practitioner's ability to provide the allowed services as evidenced by written protocols. *Quality Improvement Plan: Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician.*
Humana Response: Humana is implementing process updates to address the bulleted items. In addition, we are reviewing every credentialing file for the South Carolina Medicaid network and are in process of collecting any omitted information. Ensure independent practitioner credentialing files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. •HM4200 - 07012021 - Program Description (Credentialing Program Specific Description) – see section IV, page 4. In order to align the committee approval date, letter date and Medical Director approval date concerns raised, we plan to present all category 1 and category 2 providers to the monthly committee. The result will be the date on the letter is the same as the committee approval date.	

Standard	EQR Comments
Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician. •HM4200 - 11132020 – Policy (CORE Credentialing and Recredentialing)-001 – see page 7, first bullet The nurse practitioner requirements were updated in Humana's credentialing policy. If a nurse practitioner fails to provide a written collaborative agreement with a participating South Carolina Medicaid physician, the nurse practitioner will be terminated from the network. A written collaborative agreement is the only acceptable form of verification to satisfy this requirement.	
3.1 Verification of information on the applicant, including: 3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	For 12 provider credentialing files, CCME did not identify evidence of verification of CLIA when the provider indicated laboratory services are conducted in their offices. Humana responded that "CLIA certification is issued per facility site location, rather than issuing to an individual practitioner. Verification of CLIA for individual practitioners is not an NCQA standard or requirement. It is Humana's practice to verify CLIA when credentialing per facility site location as part of the credentialing and recredentialing process for facilities." However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8 states,* "An MCO is responsible for insuring all persons, whether they are employees, agents, Subcontractors, or anyone acting on behalf of the MCO, are properly licensed under applicable South Carolina laws and/or regulations… All applicable healthcare professionals and healthcare facilities used in the delivery of Benefits by or through the MCO shall be currently licensed to practice or operate in South Carolina as required and defined by the standards listed below." This includes "All Providers billing laboratory Procedures must have a Clinical Laboratory Improvement Amendment (CLIA) certificate." For the Medicaid Managed Care Program, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations* defines the term "provider" as "any individual, group, Physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient Centers (free-standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services." *Quality Improvement Plan: Ensure all provider credentialing files contain evidence of verification of the CLIA when the provider application indicates laboratory services are conducted in the provider's office/location.*
Humana Response: Humana is implementing process updates to address the above item. In addition, we are reviewing every credentialing file for the South Carolina Medicaid network and are in process of collecting any omitted information. If a practitioner fails to provide evidence of CLIA when the application indicates labs are performed, the practitioner will be terminated from the South Carolina Medicaid network. A paper/digital/PDF copy of the site specific CLIA or verification via QCOR are the only acceptable form of verification to satisfy this requirement. Please refer to the following: •HM4200 - 11132020 – Policy (CORE Credentialing and Recredentialing)-001, at page 5, last bullet for CLIA requirements	

Standard	EQR Comments
○Verifying CLIA for Providers (Training documentation for associates)	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	Policy (CORE Credentialing and Recredentialing (21st ed))-001A includes credentialing and recredentialing requirements specific to organizational providers. Review of 14 credentialing files for organizational providers revealed the following issues: •A total of 13 of 14 organization provider credentialing files did not contain an attestation that the information submitted was accurate. Humana responded that applications are not required from organizational providers at the time of recredentialing. •None of the files included verification of liability coverage. Humana responded that verification of liability coverage for organizational providers is not required by NCQA, and although Humana requires organizational providers to have appropriate liability coverage, this is not verified at the time of credentialing. •As noted in standard 3 above, the credentialing determination notification letters for all the reviewed organizational providers were dated prior to the credentialing determination date supplied by Humana. •The CLIA verification for two hospitals were conducted after the credentialing determination date supplied by Humana. One was 11 months after the decision date, and the other was 5 months after the decision date. Humana responded that this issue had already been identified and resulted in retraining of staff and publication of updated staff guidance documentation. *Quality Improvement Plan: For organizational provider credentialing files, ensure:* *•the files include a signed statement that the information submitted is accurate to the best of the signee's knowledge.* *•□the files include verification of liability insurance required by Humana.* *•independent practitioner credentialing files reflect the date of Medical Director approval of Category I files and that the files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.* *•CLIA verification is conducted prior to the credentialing determination.*
Humana Response: Humana is implementing process updates to address the above bulleted items. All Credentialing staff completed facility re-training and education on 05/06/2021. In addition, we are reviewing every facility credentialing file for the South Carolina Medicaid network and are in process of collecting any omitted information. The files include a signed statement that the information submitted is accurate to the best of the signee's knowledge. •Organizational Provider Credentialing Application – refer to page 6.	

Standard	EQR Comments
	•Credentialing applications are required as part of initial credentialing and recredentialing. Humana implemented a process change for South Carolina Medicaid to require formal facility assessment applications, including the attestation statement that information submitted is accurate to the best of the signee's knowledge. Humana's internal process guide for associates is being updated to reflect this change. The files include verification of liability insurance required by Humana. •HM4200 - 11132020 - Policy(CORE Credentialing and Recredentialing)-001 •Refer to page 6, last bullet for liability insurance requirement •Humana's internal process guide for associates is being updated to reflect this change. Independent practitioner credentialing files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. •HM4200 - 07012021 - Program Description (Credentialing Program Specific Description) •In order to align the committee approval date, letter date and Medical Director approval date concerns raised by SCDHHS, we plan to present all cat 1 and cat 2 providers to the monthly committee. The result will be the date on the letter is the same as the committee approval date. CLIA verification is conducted prior to the credentialing determination. HM4200 - 11132020 - Policy(CORE Credentialing and Recredentialing)-001 Page 5, last bullet for CLIA requirements •CLIA Certification for Facility Credentialing and Recredentialing – Humana's internal process guide for associates.

Each of the MCOs has established policies and procedures for suspending or terminating a practitioner's network participation for serious quality of care or service issues. The policies address processes for investigation/verification of the issue, committee and/or Medical Director involvement in rendering the final determination, and reporting requirements.

Four of the five MCOs conduct required monthly provider monitoring to ensure providers are not prohibited from receiving Federal funds. This is accomplished by querying and monitoring various databases, including Medicare/Medicaid-specific exclusions and National Practitioner Data Bank (NPDB) reports, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), licensing boards, the System for Award Management (SAM), state specific exclusions, etc. For Humana, the policy addressing monthly provider monitoring requirements did not include the requirement for monitoring the SCDHHS Providers Terminated for Cause List.

Adequacy of the Provider Network

42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 438.10(h), 42 CFR § 457.1230(a) (b), 42 CFR § 457.1230(b)

The MCOs define provider geographic access standards, appointment access standards, and processes for monitoring network adequacy in policies and procedures.

The documented geographic access standards for all plans are compliant with contractual requirements. Documentation of network evaluations for ATC, Healthy Blue, Humana, Molina, and Select Health reflected appropriate parameters were used to evaluate the network and geographic access standards were met for primary care providers and specialists. For Humana, network gaps were noted for Rehabilitative Behavioral Health, Hematology and Oncology, Gastroenterology, Otolaryngology/Otorhinolaryngology, and Speech and Audiology Therapy in a few counties. Humana reported that some of the gaps had already been closed and the plan continues to recruit providers to address the remaining gaps. Humana confirmed that for remaining gaps, agreements will be executed as needed with out-of-network providers and members will be authorized to see those providers. Select Health's Availability of Practitioners policy (Policy 159.206) did not address access parameters for occupational therapy, physical therapy, and speech/audiology therapy.

Each of the plans formally evaluates its network at least annually. ATC's Geo Access mapping from November 2021 did not include results for all SCDHHS-designated Status 1 provider types. Pediatrics practitioners were not included in the mapping. This was a repeat finding from the previous EQR. See *Table 16: ATC 2020 EQR Previous Adequacy of the Provider Network QIP* for the 2021 findings and ATC's response.

Table 16: ATC 2020 EQR Previous Adequacy of the Provider Network QIP

Standard	EQR Comments
II B. Adequacy of the Provider Network	
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	The 2020 Medicaid QI Work Plan indicates Geo Access reports are run semi-annually, and onsite discussion confirmed network reporting is provided to SCDHHS twice yearly. The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2* requires MCOs to have executed contracts with all Status 1 Providers. Additionally, the *SCDHHS Contract, Section 6.3,* requires the MCO to submit its provider network to SCDHHS "in accordance with this contract and as detailed in the Managed Care Policy and Procedure Guide" and to ensure "the submission reflects the CONTRACTOR's entire Provider network." However, the Geo Access reports (dated December 21, 2020) submitted with ATC's desk materials did not provide evidence that access was measured for the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. Additional documentation (Geo Access mapping) was provided showing measurement of General Surgery and Rehabilitative

Standard	EQR Comments
	Behavioral Health providers, but the date of the mapping was 2/26/21, after completion of the onsite. *Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all Status 1 providers. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*
ATC Response: ATC has ensured when performing its evaluation of the Network Adequacy to evaluate and measure access to all Status 1 providers as required and defined in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*	

CCME's review of health plan policies and processes to monitor provider compliance with appointment access standards revealed no issues for Molina and that Molina corrected the deficiencies identified during the previous EQR. See *Table 17: Molina Previous EQR Appointment Access QIP Items* for the previous year's findings.

Table 17: Molina Previous EQR Appointment Access QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Procedure MHSC-PS-005, Provider Availability Standards, defines standards for appointment access for PCPs and specialists. However, standards for specialty emergent visits and urgent medical condition care appointments are not included. The timeframe for routine care (non-symptomatic) specialty appointments is defined as "within 12 weeks." This timeframe is also noted in the Provider Manual, page 71. The *SCDHHS Contract, Section 6.2.3.1.5.3* defines the standard as within 4 weeks and a maximum of 12 weeks for unique specialists. *Quality Improvement Plan: Revise Procedure MHSC-PS-005, Provider Availability Standards, to include all contractually required specialty appointment standards. Refer to the SCDHHS Contract, Sections 6.2.3.1.5.1 through 6.2.3.1.5.3.*
Molina Response: MHSC-PS-005_Provider Availability Standards has been redlined with the necessary updates, see submission. The policy will be taken to our policy committee for approval in August.	

For the remaining plans, issues noted during the current year's EQR included:

- For ATC, the Evaluation of the Accessibility of Services policy (CC.PRVR.48) did not define the appointment access standards; however, the information was found in the Member Handbook and Provider Manual.

- For Healthy Blue, the Medicaid Access/Availability Standard policy (Policy MCD-11) and the Provider Manual listed included standards for both routine care appointments (within four week) and "health maintenance and preventative care" appointments (within 8 weeks). Healthy Blue staff were unable to describe the difference between routine care and health maintenance/preventive care appointments. Also, the policy did not address the appointment access requirement for walk-in patients with non-urgent needs.
- Humana's (SC Medicaid Network Availability and Access)-004 policy did not specify the frequency for conducting the Mystery Shopper Surveys to evaluate provider compliance with appointment access standards. Humana also confirmed that a Mystery Shopper Survey had not yet been conducted.
- Select Health's Accessibility of Services / PCP After Hours Survey and High Volume High Impact Survey policy (NM 159.203) did not include the requirements for wait times for scheduled routine appointments or for walk-in patients with non-urgent needs. Also, the Select Health of South Carolina Accessibility of Services report for 2021, along with onsite discussion, revealed that Select Health was evaluating providers for compliance with routine PCP appointment access standards using a much stricter timeframes than required by the *SCDHHS Contract*, Select Health policy, and the plan's Provider Manual. This is a similar finding to the finding from the previous EQR, as noted in *Table 18*.

Table 18: Select Health Previous EQR Availability of Services QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Select Health conducts an annual analysis of data to measure performance against standards for appointment access. Data includes findings from network accessibility reporting, member grievances and appeals, and CAHPS results. The objective is that 90% of the provider offices meet or exceed access standards. Additionally, an annual after-hours survey is conducted for all PCP locations. When gaps are identified, a comprehensive analysis, identifying barriers, opportunities, and appropriate interventions, is conducted. The Select Health of South Carolina Accessibility of Services Report indicates the goal of 90% was exceeded for after-hours access to primary care, PCP appointment access for routine and urgent care, and most categories for specialty appointment access. Categories for which the goal was not met included urban otolaryngology (high volume and high impact) and rural allergy (high volume). The report included barriers, opportunities for improvement, and interventions/action plans for improving access to care.

Standard	EQR Comments
	However, the Select Health of South Carolina Accessibility of Services Report indicates specialty providers were measured using an appointment access timeframe of 6-8 weeks for routine care. This is inconsistent with the timeframe listed in Policy NM 159.203. This is a repeat finding from the previous year's EQR. *Quality Improvement Plan: Revise the Select Health of South Carolina Accessibility of Services Report to reflect results of an analysis of appointment availability using the required standard of 4 to 12 weeks for routine specialty appointments. Refer to the SCDHHS Contract, Section 6.2.3.1.5.3.*
Select's Response: Due to a typographical error, a correction has been made to the Accessibility of Services report. Routine Appointment Availability of Specialist was revised to 4 – 12 weeks. This time frame matches SCDHHS contractual requirement and Select Health of South Carolina Provider Network Management departmental policy. The revised report will be presented to the February 2021 QSC Committee. A copy of the proposed revisions to the Final Accessibility Report is included.	

The MCOs have established processes to ensure their network providers can serve members with special needs such as hearing or vision impairment, foreign language or cultural requirements, and complex medical needs. The MCOs include information about Cultural Competency in Provider Manuals and on websites. However, ATC's Provider Manual directs providers to contact Provider Services or visit the plan website for more information. Information on ATC's website was found under a heading of "Medicare-Medicaid Plan (MMP) Education and Training" on the "Provider Training" page and there was no heading for Medicaid Education and Training. For Humana, several hyperlinks for Cultural Competency information in the Provider Manual were non-functional.

CCME reviewed each of the MCO's Provider Directories and related policies and procedures for compliance with state and federal requirements. Identified issues included:

- Health plan policies listing elements that must be included in the Provider Directory were missing information required by the *SCDHHS Contract, Section 3.13.5.1.1*, including age groups (ATC, Healthy Blue, Select Health), office hours (Healthy Blue, Humana, Select Health), website addresses (Humana, Molina, Select Health), and provider abilities to accommodate individuals with physical disabilities (Humana).
- Molina's print version of the Provider Directory did not include practitioner website addresses. This was a repeat finding from the 2021 EQR. See *Table 19*. Molina reported that staff were collecting website addresses from applicable providers and would produce an updated Provider Directory later in 2022.

Table 19: Molina Previous EQR Provider Directory QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	The *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR §438.10 (h) (vii)* define elements that must be included in Provider Directories. CCME's review of the hard copy Provider Directory and the online Provider Directory (via the "Find A Provider" function of Molina's website) revealed most required elements are included. However, the following required elements were not noted: •Provider website addresses. •Whether the provider has completed cultural competency training. •Whether providers can accommodate physical disabilities. *Quality Improvement Plan: Revise the Provider Directory to include all elements required by the SCDHHS Contract, Section 3.13.5.1.1 and 42 CFR §438.10 (h) (vii).*
Molina Response: Molina respectfully submits that we met the intent of the contract requirements by including this information in the footer of the directory. However, as requested by SCDHHS, we can and will add an icon in the directory related to providers that can accommodate physical disabilities and add website addresses for providers who provide to us. Since the cultural competency requirement has been discontinued for the 2021 version of the contract (related to inclusion in the directory), it is agreed that we will not retroactively adjust the directory and that no further remediation is required for this item.	

Provider Access and Availability Study

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

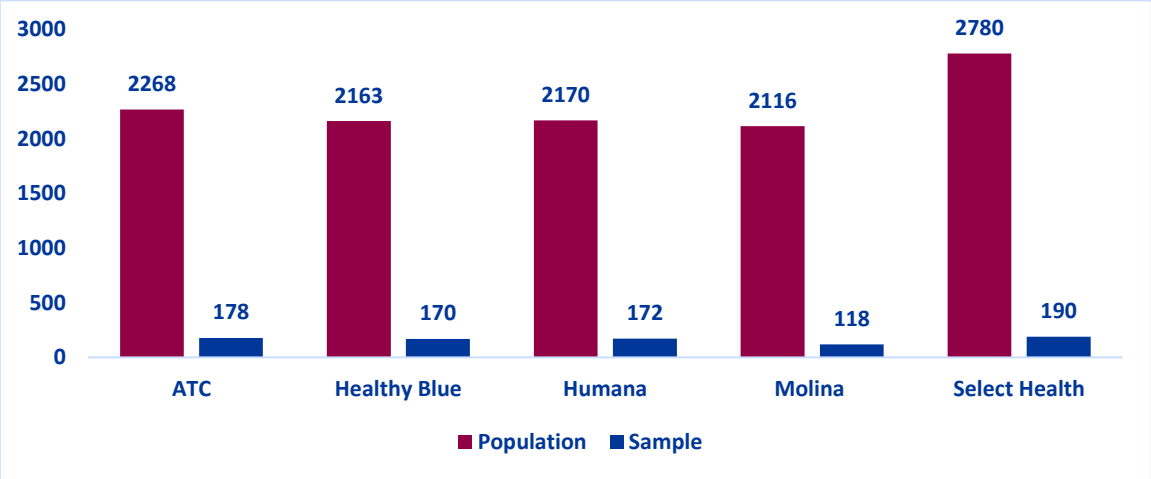
As a part of the annual review process for all plans, CCME conducted a Telephonic Provider Access Study focusing on PCPs. CCME requested and received a list of network providers and contact information from each of the health plans. From each list, CCME defined a population of PCPs and selected a statistically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

One plan received a score of "Met," and three plans received a score of "Not Met" for the standard requiring an improvement in the results of the Telephonic Provider Access Study. For one plan, the standard was not evaluated as this is the baseline year. The following charts summarize the Provider Access and Availability Study findings and compare the five plans surveyed.

Population and Sample Size

From the five MCOs reviewed, CCME identified a total population of 11,497 PCPs. From each plan's population, CCME randomly selected a total of 828 providers, as shown in *Figure 3: Population and Sample Sizes for Each Plan*.

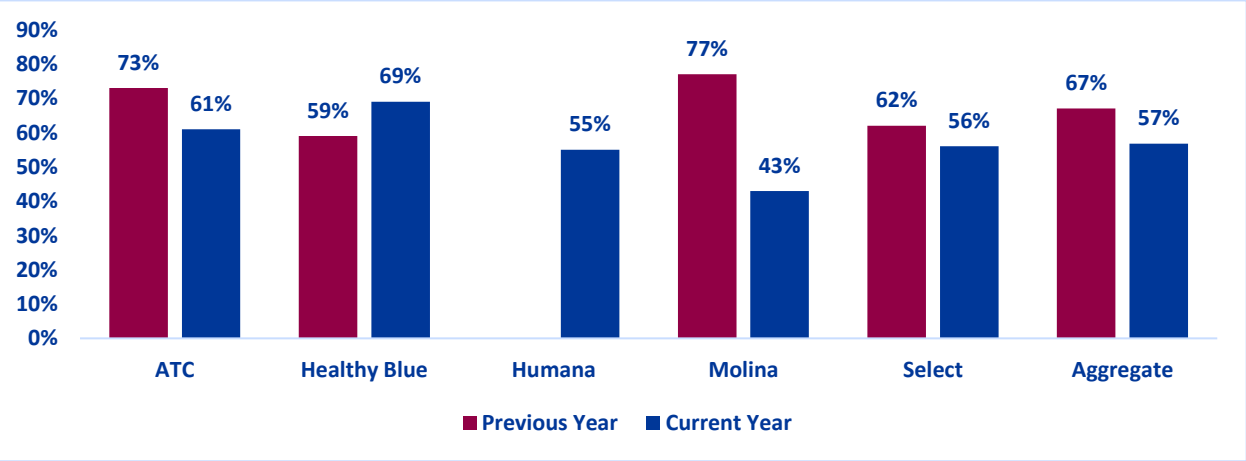
Figure 3: Population and Sample Sizes for Each Plan



Successfully Answered Calls

Of the successfully answered calls, 57% of providers across the plans responded that the provider accepts the respective health plan, representing a ten-percentage point decrease from the previous year's rate of 67% when considering the success rate of the four plans included in the calculation. *Figure 4: Percentage of Providers Accepting the Plan* displays the percentage of providers that indicated they accept the plan.

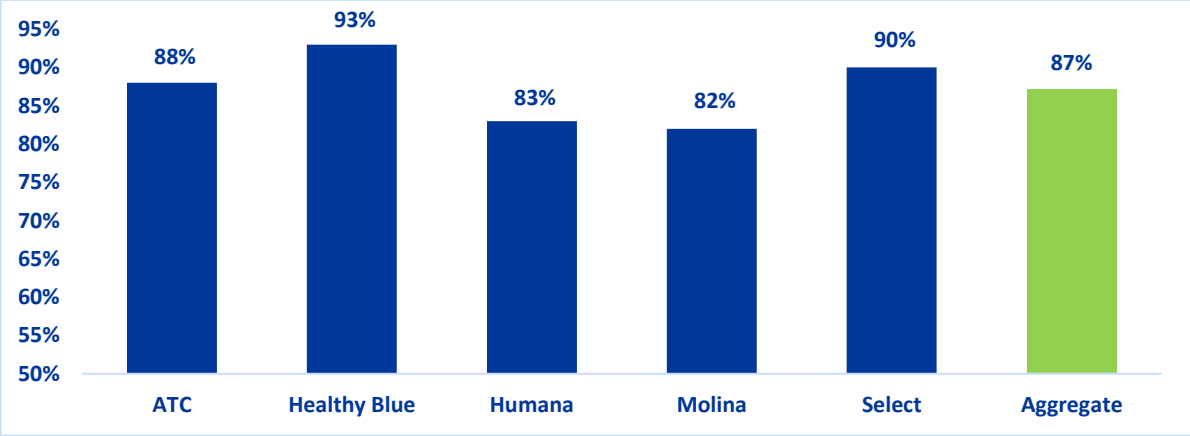
Figure 4: Percentage of Successfully Answered Calls



Currently Accepting the Plan

In aggregate, 87% of the providers responded that they accept the Plan, which is a 2-percentage point decline from last year's rate of 89%. See *Figure 5: Percentage of Providers Accepting Medicaid Patients*. Individual plan results ranged from 82% to 93%.

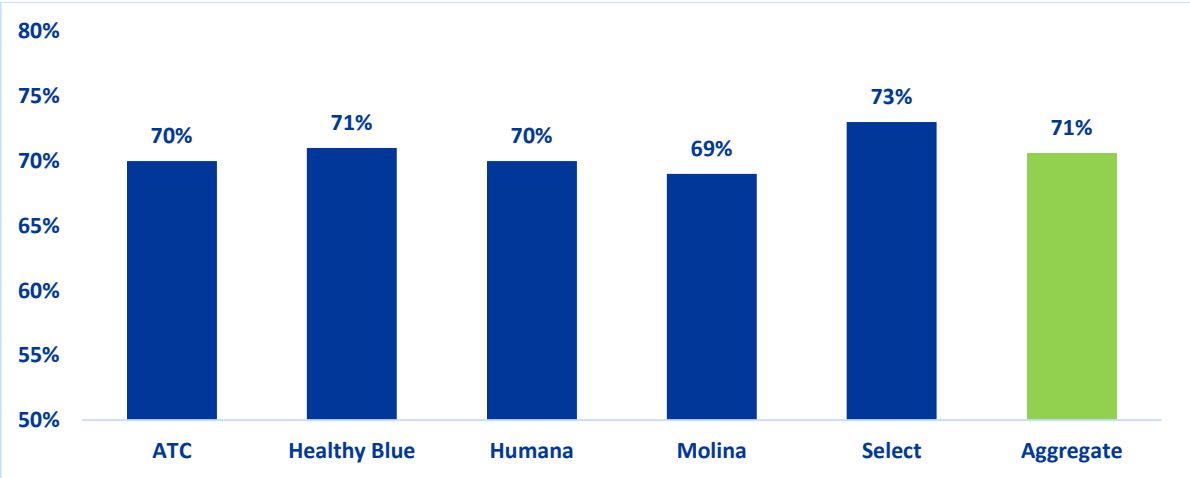
Figure 5: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

In aggregate, 71% of the providers accepting the plan responded that they are accepting new Medicaid patients, which is a three point decline from last year's rate of 74%. See *Figure 6: Percentage of Providers Accepting Medicaid Patients*. Individual plan results range from 69% to 73%.

Figure 6: Percentage of Providers Accepting Medicaid Patients



Summary of Study Findings

For the five plans, overall access to providers improved for one plan and declined for three plans as indicated by the changes in the percentage of successfully answered calls in the Telephonic Provider Access Study. One plan has a baseline rate for this current review and was unable to be evaluated for decline or improvement.

The percentage of providers that are currently accepting the plans (87%) is a decrease from last year's rate of 89%. The study also revealed a 3% decline in providers accepting new Medicaid patients when compared to last year's rate. Of the four plans with year-over-year trending data available for success rates, one plan met the standard for improvement from the previous Telephonic Provider Access Study results and three plans did not meet the standard for improvement.

Tables 20 through 22 list the findings from the previous Provider Access and Availability Studies for Healthy Blue, Molina, and Select Health, and each plan's response to those findings.

Table 20: Healthy Blue Previous EQR Provider Access and Availability Study QIP Items

Standard	EQR Comments
II. B. Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	The Healthy Blue Provider File contained a population of 2,430 PCPs. From that, a random sample of 176 PCPs was selected for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only Providers located in SC and documented as accepting new patients were selected for the sample. 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 CCME, calls were successful 59% of the time. When compared to last year's results of 77%, the decrease in successful answer rate was statistically significant (p = .0002). For those not answered successfully (n=67 calls), 33 (49.3%) were unsuccessful because the provider was not at that office or phone number listed. *Quality Improvement Plan: Examine current methods to update provider information; ensure all provider files are up to date; offer providers several methods to update contact information and primary location. Check the unsuccessful calls file from CCME.*
Healthy Blue's Response: We have reviewed the unsuccessful call file provided by CCME. Using the file, we determined several updates to the provider directory were needed. We also discovered, however, that some	

Standard	EQR Comments
Hospitalists not listed in our provider directory – but listed in the provider file we provide to auditors - had been contacted by the auditors. While the provider primary specialties for the Hospitalists are that of PCPs, the providers were in fact suppressed from our directory since they are practicing as Hospitalists and not PCPs. We will make every effort to make this distinction in future files pulled from our system to send to auditors. Here are some current and future enhancements to verify and update Provider Data: •Secret Shopper Outreach and Provider Education Outreach – calls placed to providers as a potential new patient asking questions related to office address, accepting new patients and network participation. Then, verification calls are placed as caller from the payor. •Providers may validate their information via email, telephone, or our online portal: MDCheckup. All locations are prompted to verify their data at least once per quarter via MDCheckup messages, email and/or telephone outreach by BlueChoice HealthPlan. •As a future process improvement, the Healthy Blue/BlueChoice HealthPlan Compliance Department will conduct provider directory audits, with the assistance of two new Managers, expected to be hired by end of 3rd Quarter 2021. Results of this audit will be shared with the Provider Data team to make updates to data as needed, or as additional verification of data. The Compliance Department's audits will be in addition to audits/analyses currently performed by the Provider Data Management team.	

Table 21: Molina Previous EQR Provider Access and Availability Study QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	Molina submitted a Provider File containing a population of 2,459 unique providers, from which a random sample of 180 PCPs was selected for the provider access study conducted by CCME. For the telephonic Provider Access Study conducted by CCME, attempts were made to contact sample of providers to ask a series of questions regarding the access that members have with the providers. Calls were successfully answered 63% of the time (103 of 164) when omitting 16 calls answered by personal or general voicemail messaging services. This is a statistically-significant decline from last year's rate of 74%. *Quality Improvement Plan: Provide documentation of specific methods and action steps to improve accuracy of provider contact information and status/location. Determine if additional applications need to be involved to maintain accurate files for provider location, number, and active status.*
Molina Response: Molina is aware of the need for accurate and correct contact information for each provider in our network directory. We make every attempt to maintain current information for the benefit of our members. Several of the "fails" that you listed are included under a delegated agreement with Prisma Health. Upon receipt of the list of providers contacted by CCME, we did a follow-up survey of those who were listed as "failed" and found that these providers were included in the rosters for January 2021 and April 2021 with the same address and phone number as provided in our listing to you.	

Standard	EQR Comments
A sample of providers from the 'fail' list was contacted with the following results: One (1) provider got married and changed their last name; we found multiple others that were still with the provider group, however, were no longer practicing at that specific location. In attempt to improve our directory for the future, we will send a request via fax blast 2x/year for updated current information that can be cross walked with the information in our system that is included in provider rosters. Additionally, we will use CAQH ProView for all non-delegated groups and have providers attest that their information is current at least annually. Contractually, providers are required to notify Molina within 30 days of any provider changes, however, this does not always occur.	

Table 22: Select Health Previous EQR Provider Access and Availability Study QIP Items

Standard	EQR Comments
II B. Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	As part of the annual EQR process for Select Health, a provider access study was conducted focusing on primary care providers. A list of current providers was given to CCME by Select Health, from which a population of 2,794 unique PCPs was found. A sample of 192 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access members have with the providers. During the Telephonic Provider Access Study conducted by CCME, calls were successfully answered 77% of the time (130 of 168 calls) when omitting calls answered by personal or general voicemail messaging services. The success rate slightly reduced from last year's rate of 81%. This is not a statistically significant decline (p = .520). *Quality Improvement Plan: Set a plan for provider network management workgroup to review records to ensure provider contact information is updated and initiate new interventions to update provider information.*
Select's Response: Provider Network Management (PNM) initiated a project/workgroup in February 2019 where the Account Executives review 30 provider records each month and confirmed with the provider office any updates and/or changes that are needed to their information. The project has been in place however due to COVID outreach efforts were complicated due to the state of emergency mandates on Providers. Effective January 2021, PNM will coordinate and lead the monthly meeting with Provider Network Operations Department and other necessary departments to review these results. The results from this workgroup will be presented to the Quality of Service Committee (QSC).	

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Health plan policies document processes for initial orientation of newly contracted providers and ongoing provider education activities. In general, new provider orientation includes necessary information and materials to understand health plan requirements and processes. Humana's (Provider Training)-009 policy was incomplete regarding items that may be mailed to new provider offices, referenced another state's Provider Manual, and contained multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist that Humana staff confirmed is not used. Humana's Provider Manual contained incorrect information about member benefits. Molina's Provider and Practitioner Education procedure (MHSC-PS-010) did not specify the timeframe within which the initial provider orientation is conducted.

The health plans provide ongoing provider education about changes to the programs, practices, benefits, policies, and procedures. The ongoing education is provided through a variety of forums, including virtual and in-person sessions, electronic and mailed educational materials and updates, website updates, newsletters, etc.

Overall, health plan policies define the medial record documentation standards; however, Select Health's Medical Record Review policy (Policy QI 154.009) and Attachment A, Medical Record Review Evaluation Form, did not include all required medical record documentation elements as stated in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)*. Each of the MCOs educate their network providers about medical record maintenance, storage, and required elements of medical record documentation. Providers are informed that they will be assessed for compliance with medical record documentation standards through annual medical record audits. Processes for conducting the annual medical record audits are detailed in policies. No issues were identified in ATC's and Healthy Blue's documentation. The remaining MCOs' documentation did not include the frequency of provider medical record audits (Humana), the timeframe for re-audits for providers who do not successfully pass the initial audit and over-read (Molina), and the benchmark score for medical record reviews (Select Health). Documentation confirmed each of the MCOs routinely conducts provider medical record audits. Results are analyzed, reported to appropriate quality committees, and used for quality improvement activities. Select Health's 2021 Annual Assessment of State Audits for Medical Record Documentation report indicated not all required elements from the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.7 (O)* were included.

Preventive Health and Clinical Practice Guidelines

42 CFR § 438.236, 42 CFR § 457.1233(a)

Appropriate processes are established by each of the MCOs for adoption, review, and revision of preventive health guidelines (PHGs) and clinical practice guidelines (CPGs). The guidelines are relevant to the MCOs' membership and are adopted from nationally-recognized, evidence-based guidelines. Network providers are educated about the PHGs and CPGs through routine provider education sessions, Provider Manuals, health plan websites, mailings, and newsletters. The plans encourage providers to use the guidelines and monitor provider compliance through HEDIS monitoring and medical record audits.

Continuity of Care

42 CFR § 438.208, 42 CFR § 457.1230(c)

Processes are in place for each the MCOs to monitor continuity and coordination of care between PCPs and other providers through medical record reviews, appeals and grievances, satisfaction surveys, review of quality of care and quality of service issues, etc. Each of the plans monitors and analyzes data regarding continuity of care, reports to appropriate committees, and uses the data for quality improvement activities and to improve continuity and coordination of care.

During Humana's previous review, the process for monitoring coordination of care between providers could not be identified. The current review confirmed that Humana addressed this finding by developing Policy (Coordination of Care), which described the process for monitoring coordination of care between providers and included methods of monitoring, assessment, and addressing identified deficiencies. See *Table 23* for the previous review findings and Humana's response.

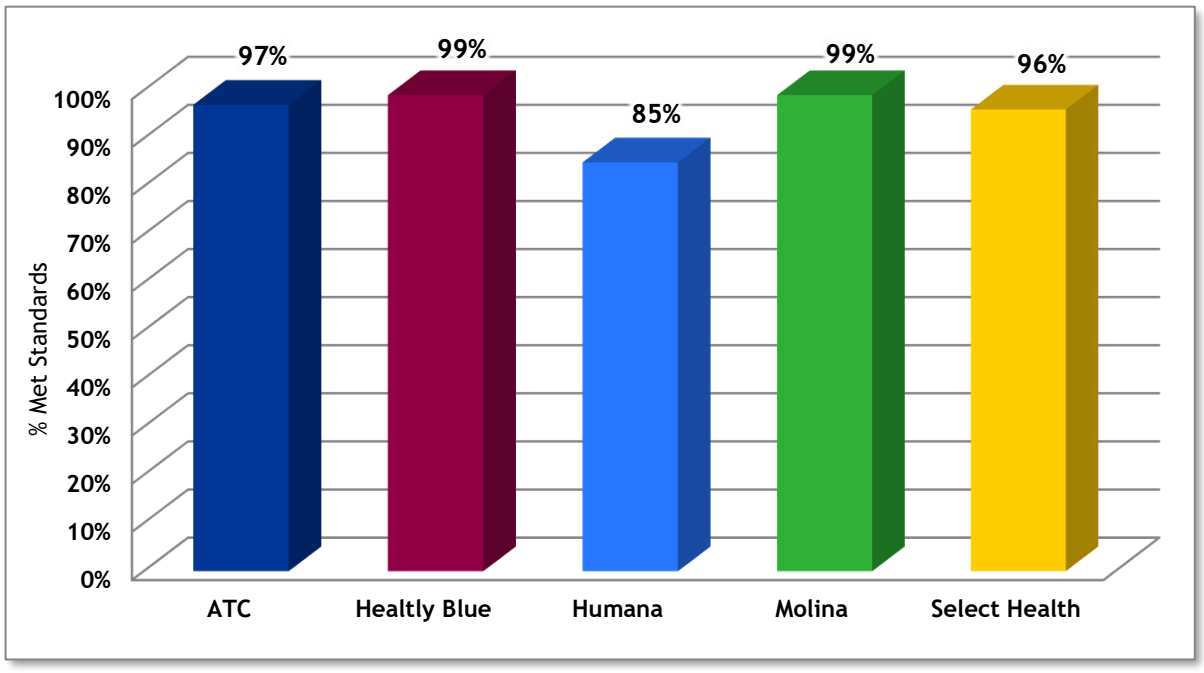
Table 23: Humana Previous EQR Continuity of Care QIP Items

Standard	EQR Comments
II F. Continuity of Care	
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	The Provider Manual and Policy (External Quality Review)-006 HUM-SC-QM-008-01 indicate that medical records must contain documentation of referrals and results of referrals, documentation of emergency and/or after hours encounters and follow-up, and consultation reports. Pages 44-45 of the QI Program Description states coordination of care for members is assessed between settings of care and in transitions of care from one provider to another. Data sources listed in the program description for this activity include medical record reviews, HEDIS measurements, CAHPS results, Case/Disease Management data, and grievance and complaint data. However, the process for monitoring coordination of care between providers could not be identified in the program description or in a policy.

Standard	EQR Comments
	Quality Improvement Plan: Ensure Humana's process for monitoring coordination of care between providers is documented in a policy, including methods of monitoring and assessment, processes for addressing any identified deficiencies, etc. PCPs should be aware of care members receive elsewhere, such as emergency rooms, from specialists, etc.
Humana Response: Humana has documented its process for monitoring coordination of care between providers in its Continuity and Coordination of Care Policy and Medical Records Review Policy. As reflected in these policies, Humana collects and analyzes data reflecting member movement between providers, facilitating Humana's ability to ascertain whether PCPs are aware of such movement. These data sources include, for example, medical records identifying services provided through the MCO to include the name of the service providers, as well as documentation of emergency and after-hours encounters and follow up visits. Additionally, Humana analyzes data from various other sources, including but not limited to, provider and member survey feedback, HEDIS results, physician and facility correspondence, and disease and case management data. Humana utilizes the data to determine whether PCPs are aware of members receiving care elsewhere. If Humana's medical record review sampling process reveals that the provider failed to maintain appropriate records for the member, and thus is unaware of the member's movements between providers, then Humana undertakes additional steps to improve the PCP's compliance with the requirement for providers to maintain a comprehensive health record reflecting all aspects of care for the member. The Medical Record Review Policy also sets forth the actions that occur should a PCP score below the minimum threshold regarding records the provider maintains for the member, including, for example, additional investigation, corrective actions to be undertaken with the PCP, and consideration of same during the recredentialing process. Please refer to the following documents: • HUM4200 - 07012021 - Policy (Coordination of Care) • HUM4200 – 07212021-Policy (Medical Record Review)-013 at pages 2-3	

The percentages of "Met" scores achieved by each plan for the Provider Services section of the review are illustrated in *Figure 7: Provider Services*.

Figure 7: Provider Services



An overview of the scores for the Provider Services section is illustrated in *Table 24: Provider Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 24: Provider Services Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Met	Partially Met	Met	Met	**Strengths:** ▶ Each MCO has a Credentialing Committee that makes credentialing determinations using a peer-review process. ▶ The MCOs have established policies and procedures for suspending or terminating a practitioner for serious quality of care or service issues. ▶ Four of the five MCOs had no issues identified with practitioner credentialing and recredentialing policies and files. **Weaknesses:** ▶ Humana's Policy (CORE Credentialing and Recredentialing)-001 did not address querying the SCDHHS Termination for Cause List and Policy (Core Sanctions Policy)-002 did not include the SCDHHS SC Provider Terminated for Cause List as a required monthly monitoring element. ▶ Although membership of the plans' credentialing committees includes network practitioners, ATC's committee included only one external network provider (pediatrics). Select Health 's committee did not include any mid-level practitioners and member attendance for several
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Met	Met	Met ↑	Met	Met	
The credentialing process includes all elements required by the contract and by the MCO's internal policies.	Met	Met	Not Met ↓	Met	Met	
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met	
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met	
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met	
Work history	Met	Met	Met	Met	Met	
Malpractice claims history	Met	Met	Met	Met	Met	
Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application						members was below the established attendance requirement. ▶ Humana's credentialing and recredentialing files for practitioners and organizational providers revealed issues related to the dating credentialing approval letters prior to the date of the documented approval of credentialing (a repeat finding from the Readiness Review), failure to collect collaborative agreements for nurse practitioners (a repeat finding from the Readiness Review), failure to query the SCDHHS SC Providers Terminated for Cause List and Excluded Providers Report, and failure to query the Social Security Administration's Death Master File. **Recommendations:** • The MCOs should review policies and procedures to ensure all required elements of credentialing/recredentialing and required provider monitoring are addressed. • The MCOs should work to recruit additional providers for membership of credentialing committees to ensure peer representation, including mid-level practitioners, on the committee. • Ensure member attendance of health plan credentialing committees meets established attendance expectations.
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	
Not debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM)	Met	Met	Met	Met	Met	
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met	
Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Met	Not Met↓	Met	Met	
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met	
Query of Social Security Administration's Death Master File (SSDMF)	Met	Met	Partially Met ↓	Met	Met ↑	
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met	
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Met ↑	Met ↑	Met	Met	
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met	
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Not Met ↓	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Recredentialing conducted at least every 36 months	Met	Met	Met	Met	Met	• Ensure credentialing and recredentialing files include evidence of all required credentialing elements and that provider credentialing/recredentialing determination letters are not dated prior to the determination date.
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met	
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met	
Board certification if claimed by the applicant	Met	Met	Met	Met	Met	
Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met	
Practitioner attestation statement	Met	Met	Met	Met	Met	
Requery the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met	
Requery of System for Award Management (SAM)	Met	Met	Met	Met	Met	
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met	
Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list	Met	Met	Not Met ↓	Met	Met	
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met	
Query of the Social Security Administration's Death Master File (SSDMF)	Met	Met	Partially Met ↓	Met	Met	
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met	
In good standing at the hospitals designated by the provider as the primary admitting facility	Met	Met	Met	Met	Met	
Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Met ↑	Met	Met	Met ↑	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Review of practitioner profiling activities	Met	Met	Met	Met	Met	
The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Met	Met	Met	Met	
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Met	Met	Not Met ↓	Met	Met	
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Met	Partially Met ↓	Met	Met	
Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 438.10(h), 42 CFR § 457.1230(a) (b), 42 CFR § 457.1230(b)*						
The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements. Members have a primary care physician located within a 30-mile radius of their residence	Met	Met	Met	Met	Met	**Strengths:** ▶ The MCOs have defined geographic access standards for primary care and specialty providers and established processes to routinely monitor and assess provider network adequacy. ▶ The health plans monitor and evaluate their networks' abilities to serve members with special needs and provide information about cultural competency in Provider Manuals and on websites. ▶ The MCOs maintain online provider directories and either published or "on-demand" print provider directories. ▶ The MCOs routinely monitor provider compliance with appointment access standards.
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	Met	Met	Met	Met	Met	
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Met	Met	Met	▶ Plans have continued to introduce and revise data-driven processes and methods to update provider contact information **Weaknesses:** ▶ ATC's Geo Access mapping from November 2021 did not include results for all SCDHHS-designated Status 1 provider types. This was a repeat finding from the previous EQR. ▶ Health plan policies define elements that must be included in Provider Directories; however, the policies for all plans failed to include one or more of the required elements. ▶ Molina's printed Provider Directory did not include practitioner website addresses. ▶ Policies do not address all contractually mandated appointment access standards (ATC, Healthy Blue, Select Health) and/or include incorrect information (Healthy Blue). ▶ For the Telephonic Provider Access Studies conducted by CCME, three of five MCOs did not show improvement from the previous study's results. **Recommendations:** • Ensure Geo Access mapping and other network evaluations include all required Status 1 provider types.
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met	
The MCO maintains a provider directory that includes all requirements outlined in the contract	Met	Met	Met	Met ↑	Met	
The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met ↓	Met	Met ↑	Partially Met ↑	
The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met ↓	Met ↑	Not Evaluated	Not Met	Not Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						• Review policies about Provider Directory requirements to ensure all required elements are addressed. • Ensure Provider Directories include all required elements. • Review policies to ensure all contractually mandated appointment access standards are addressed and the information is correct. • Update provider enrollment files on a timely basis to reflect active providers that are accepting the health plan. • Develop and implement processes to improve accuracy of provider contact information, status, and location. • Determine additional methods to maintain updated provider status in provider files.
Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Partially Met ↓	Met	Met	**Strengths:** ▶ Each of the plans conduct initial provider orientation and ongoing provider education to ensure providers are kept up to date about health plan processes, requirements, provider responsibilities, etc. ▶ Provider orientation and ongoing education are provided through virtual and in-person sessions,
Initial provider education includes: MCO structure and health care programs	Met	Met	Met	Met	Met	
Billing and reimbursement practices	Met	Met	Met	Met	Met	
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Met	Partially Met ↓	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Procedure for referral to a specialist	Met	Met	Met	Met	Met	electronic and mailed educational materials and updates, website updates, newsletters, etc. **Weaknesses:** ▶ Health plan policies about provider orientation and education contained omissions of information and errors in documentation (Humana and Molina). ▶ Humana's Provider Manual contained incorrect information about member benefits. **Recommendations:** • Review and revise policies about provider orientation and ongoing education to ensure the information is complete and correct. • Ensure documentation of member benefits is correct in Provider Manuals.
Accessibility standards, including 24/7 access	Met	Met	Met	Met	Met	
Recommended standards of care	Met	Met	Met	Met	Met	
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met	Met	
Provider and member grievance and appeal procedures	Met	Met	Met	Met	Met	
Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met	Met	Met	Met	
Reassignment of a member to another PCP	Met	Met	Met	Met	Met	
Medical record documentation requirement.	Met	Met	Met	Met	Met	
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	Met	Met	Met	Met	
Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Met	Met	Met	**Strengths:** ▶ Appropriate processes are established by each of the MCOs for adoption, review, and revision of preventive health guidelines (PHGs).
The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The preventive health guidelines include, at a minimum, the following if relevant to member demographics: Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Met	Met	Met	Met	▶ The guidelines are relevant to the MCOs' membership and are adopted from nationally-recognized, evidence-based sources. ▶ Network providers are educated about the PHGs through routine provider education sessions, Provider Manuals, health plan websites, mailings, and newsletters. ▶ Each of the plans encourages providers to use the guidelines and monitors provider compliance through HEDIS monitoring and medical record audits.
Recommended childhood immunizations	Met	Met	Met	Met	Met	
Pregnancy care	Met	Met	Met	Met	Met	
Adult screening recommendations at specified intervals	Met	Met	Met	Met	Met	
Elderly screening recommendations at specified intervals	Met	Met	Met	Met	Met	
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met	
Behavioral Health Services	Met	Met	Met	Met	Met	
Clinical Practice Guidelines for Disease and Chronic Illness Management *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met	**Strengths:** ▶ Appropriate processes are established by each of the MCOs for adoption, review, and revision of clinical practice guidelines (CPGs). ▶ The guidelines are relevant to the MCOs' membership and are adopted from nationally recognized, evidence-based sources.

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Met	Met	Met	Met	▶ Network providers are educated about the CPGs through routine provider education sessions, Provider Manuals, health plan websites, mailings, and newsletters. ▶ Each of the plans encourage providers to use the guidelines and monitors provider compliance through HEDIS monitoring and medical record audits.
Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
The MCO monitors continuity and coordination of care between the PCPs and other providers	Met	Met	Met ↑	Met	Met	**Strengths:** ▶ The plans monitor and analyze data regarding continuity of care, report to appropriate committees, and use the data for quality improvement activities and to improve continuity and coordination of care.
Practitioner Medical Records						
The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Met	Met	Met	Met	Met	**Strengths:** ▶ Each of the MCOs has processes established to ensure provider compliance with medical record documentation standards. ▶ Results of medical record audits are analyzed, reported to appropriate quality committees, and used for quality improvement activities.
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Met	Met	Met	Partially Met ↓	
The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	Met	Met	Met	Met	**Weaknesses:** ▶ Issues noted in the MCOs' policies included failure to include all required medical record documentation elements (Select Health), lack of documentation of the frequency of provider medical record audits (Humana), the timeframe for re-audits for providers who do not successfully pass the initial audit and over-read (Molina), and the benchmark score for medical record reviews (Select Health). ▶ Select Health's 2021 Annual Assessment of State Audits for Medical Record Documentation report indicated not all required medical record documentation elements were included. **Recommendations:** • The MCOs should review and revise medical record documentation policies and procedures to ensure all required medical record documentation elements are addressed. The policies should clearly reflect the processes for evaluating provider compliance, including frequency of audits, timeframes for follow-up of providers who do not pass the initial audit, and benchmark scores. • When conducting medical record audits, ensure all required elements are being evaluated.

C. Member Services

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

The review of Member Services encompassed member rights and responsibilities, member education, processes for enrollment and disenrollment, member satisfaction surveys, grievance processes and requirements, and a review of a sample of grievance files.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

Each of the MCOs had policies and procedures that define member rights and responsibilities, as well as processes for informing members and providers of those rights and responsibilities. Members are informed of their rights and responsibilities in a variety of ways, including but not limited to new member welcome packets, Member Handbooks, and newsletters. Member rights and responsibilities are found on each of the plans' websites.

Member Education

42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)

Policies and procedures outline processes for providing new members with enrollee information and for ongoing member education. Welcome packets provide information for new members to understand the health plans, benefits, requirements, and processes. A wealth of information is provided on plan websites, and members may contact the Member Services call centers for additional information and assistance. In addition, 24-hour nurse lines are available for members who need medical advice and other health information, assistance in determining where to go for care, information benefits and services, etc. The MCOs educate members about available preventive health and disease management services through Member Handbooks, mailings, and newsletters. Members are encouraged to participate in available wellness and preventive services through reminder campaigns, text programs, call center staff, incentive programs, etc.

Humana's Member Handbook did not include full benefit information for chiropractic services, communicable disease services, newborn hearing screenings, rehabilitative therapies for children, BabyNet Services, and transplant services.

Tables 25 and 26 below describe the Member Education deficiencies identified for Humana and Select Health during the previous EQRs. Each of the deficiencies was confirmed to be corrected during the most recent EQRs.

Table 25: Humana's Previous EQR Member Education QIP Items

Standard	EQR Comments
III B. Member MCO Program Education	
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: 1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;	The Member Handbook states Humana will send letters to members within 15 days prior to the effective date of their PCP's termination. Documentation of Humana's process for notifying members of changes in benefits 30 days before the effective date was not found in the Member Handbook. During the onsite, Humana staff explained that members are informed in writing of significant changes to benefits 30 days in advance of the effective date. *Quality Improvement Plan: Include information in the Member Handbook that members will be informed of benefit changes in writing 30 days before the effective date, as required by the SCDHHS Contract, Section 3.13.*
Humana Response: Please refer to SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 page 46.	
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;	The Member Handbook provides limited information on EPSDT preventive services and does not adequately educate members about the requirements for this service. It includes basic information explaining that EPSDT services are for members from birth to their 21st birthday and has a bulleted list of EPSDT exam components. Unlike the Provider Manual, the Member Handbook does not provide a detailed description or definition of EPSDT preventive services such as a description of preventive exam components, the recommended age-appropriate exam intervals, or references to the AAP and Bright Futures Periodicity Schedule. During the onsite, Humana staff reported the AAP and Bright Futures Periodicity Schedule will be available on the website once it is up and running. *Quality Improvement Plan: Edit the Member Handbook to expound on EPSDT Preventive information by including definitions and description of required examinations and the recommended schedule for members to obtain age-appropriate services.*
Humana Response: Please refer to SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 at page 50 - 52.	
3. Members are informed in writing of changes in benefits and changes to the provider network.	Humana will notify members in writing within 15 days prior to the effective date of their PCP's termination as noted in Policy (SC Medicaid Provider Terminations and Member Notifications). There was no documentation provided regarding how Humana will notify members of changes in benefits. *Quality Improvement: Document in a policy the process for informing members in writing of changes in benefits as required by the SCDHHS Contract Section 3.13.*

Standard	EQR Comments
Humana Response: Humana has updated its Marketing and Member Communication Policy, as well as its Core Benefits & Services Policy to include the process for informing members in writing of changes in benefits. Please refer to the following redlined documents: • HM4200 - 11162020- Policy (MARKETING)-001 at page 8 • HM4200 - 07012021 - Policy(UM- Core Benefits and Services)-007 at page 20 6/9 - For line 18, we revised and submitted the UM Core Benefits Policy and updated the QIP tool / chart response 6/11 – See additional information uploaded.	

Table 26: Select Health's Previous EQR Member MCO Program Education QIP Items

Standard	EQR Comments
III B. Member MCO Program Education	
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:	Policy MEM 129.107, New Member Orientation Calls, states new members are mailed a First Choice New Member Packet within 30 days of enrollment notification and a Member ID Card within 15 days. During the onsite teleconference, Select Health staff confirmed New Member Packets and ID cards are mailed within 14 days of receiving enrollment information. The packet includes the Notice of Privacy Practices, Quick Start Guide, Personal Representative Form, and a welcome letter. Policy MEM 129.124, Member Requested Print Material, page 3, indicates members will receive a copy of the Member Handbook upon enrollment. However, staff confirmed new members receive a New Member Packet with instructions to access the Member Handbook from the website. This issue was discussed in the previous EQR with a recommendation to correct it. *Quality Improvement Plan: Correct Policy MEM 129.107, New Member Orientation Calls, to reflect New Member Packets and ID Cards are mailed within 14 days of receiving enrollment, instead of 30 days and 15 days, respectively. Refer to the requirement in the SCDHHS Contract, Section 3.14.3.*
Select Health: Policy MEM 129.107 was updated to state New Member packet is mailed within 14 days of receiving enrollment information. The proposed revisions will be submitted to the Policy and Procedure team in January 2021. A copy of the proposed revisions is included. Policy MEM 129.124 Member Requested Print Material, page 3, New Member Packet was updated on November 17, 2020. The revisions were in the definitions section of the policy. The definition of New Member Packet was changed to mean the following: Package sent to new members upon enrollment within the plan. Contents include the Welcome Letter, Quick Start Guide, Personal Representative Form and Notice of Privacy Practices.	

Member Enrollment and Disenrollment

42 CFR § 438.56

Appropriate processes are in place for member enrollment and disenrollment and are documented in health plan policies. The health plans allow members to select a PCP upon enrollment, to change their PCP at will, and aid with these processes. MCO-initiated member disenrollment requests are compliant with contractual requirements.

Member Satisfaction Survey

Member Satisfaction Survey validation was conducted based on the CMS Survey Validation Protocol. The MCOs conduct annual Member Satisfaction Surveys using certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors. The survey results are used to identify quality issues/opportunities for improvement and to implement strategies to address them. Results are reported to the plans' Quality Committees and to network providers.

Humana's survey results were expected to be available in June/July 2022; therefore, the validation of Humana's Member Satisfaction Survey was not conducted for this review cycle.

For Healthy Blue, the Child survey response rate showed a large increase of 8.96% from the previous year. The Child with Chronic Conditions response rate showed a substantial increase of 10.12% from the previous year. of 22.24%. The Adult survey response rate showed a small increase of 1.39% from the previous year. For the remaining health plans, the following issues were noted with response rates:

- ATC's response rates declined over the past three survey cycles.
- Molina's response rates were below the NCQA target of 40% and showed decreases from the previous year of: 1.9% (Adult), 1.4% (Child), and 2.1% (Child with Chronic Conditions).
- For Select Health, all response rates decreased from the 2019 response rates and were below the NCQA target of 40%.

Grievances

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

Processes and requirements for receiving, investigating, and resolving grievances are documented in health plan policies and procedures. Information about grievance processes and requirements is also found in the MCOs' Member Handbooks, Provider Manuals, and on websites. Documentation appropriately defines grievance terminology, persons who may file a grievance, and filing requirements. No issues were noted with documentation of grievance acknowledgement and resolution timeframes. The health

plans ensure that clinical grievances and grievances related to the denial of expedited appeal resolution are reviewed by a Medical Director or an alternate physician designee.

CCME reviewed a sample of grievance files from each of the health plans. For ATC, Molina, and Select Health, no issues were identified. For Healthy Blue, grievance files reflected that the plan does not consistently follow its own policy regarding the timeframe for acknowledging grievances. Humana's grievance files revealed issues with the timeliness for sending acknowledgement letters, untimely grievance resolution, and not taking appropriate action to resolve a member's request for a list of PCPs in her area.

The health plans track, categorize and analyze grievances for trends, patterns, and opportunities for improvement. Grievance data are routinely reported to appropriate Quality committees.

As noted in *Table 27: Humana's Previous EQR Grievances Deficiencies and QIP Responses*, several issues were identified during Humana's previous EQR. The current EQR for Humana confirmed these issues were addressed and adequately corrected.

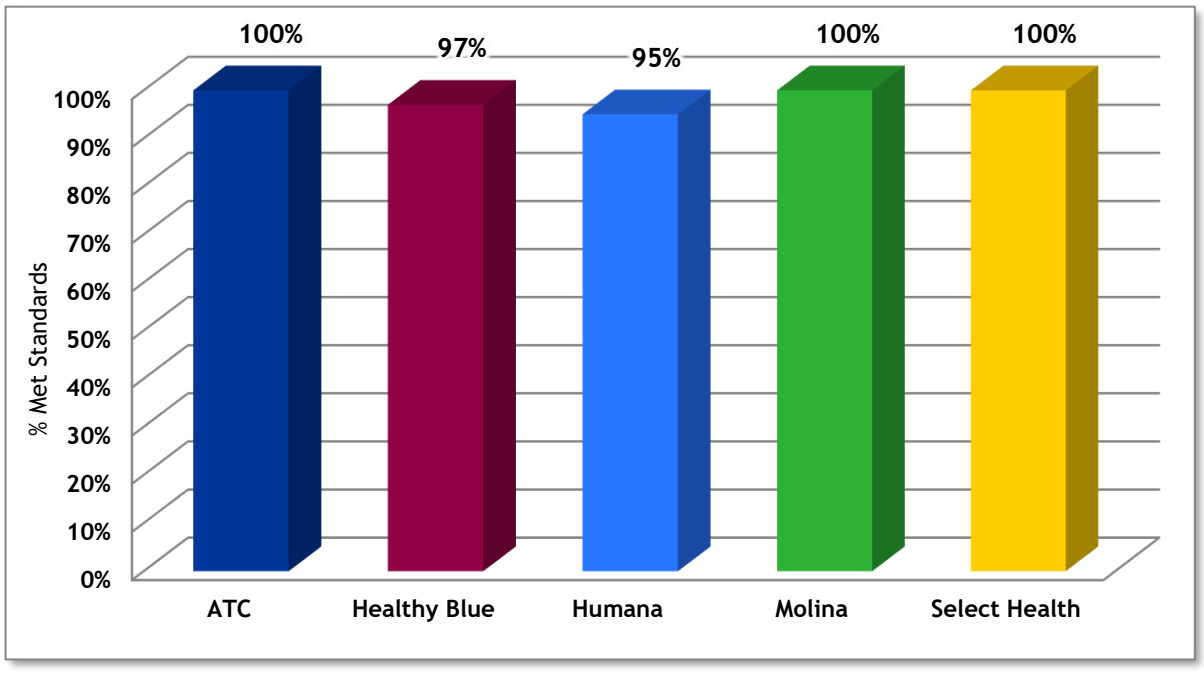
Table 27: Humana's Previous EQR Grievances Deficiencies and QIP Responses

Standard	EQR Comments
III F. Grievances	
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.2 Procedures for filing and handling a grievance;	Humana processes grievance for benefits and services that are provided by the plan. Humana's staff and the Member Handbook confirmed the plan does not provide dental benefits to members and does not process grievances for dental services. However, the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C document states, "This process applies to medical and dental." The following documentation issues for filing and handling grievance were identified: •Grievance acknowledgement timeframes are documented in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document. However, acknowledgment timeframes are not included in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E. •The South Carolina Medicaid Grievance First Level Review-001F document (page 8) incorrectly documents the grievance filing timeframe as "30 calendar days." According to requirements in *SCDHHS Contract, Section 9.1.1.2.1,* grievances can be filed at any time. •The table of "Important Phone Numbers" on page 26 of the Member Handbook lists 1-800-372-2973 as the number to contact for

Standard	EQR Comments
	grievances related to Medicaid Services. However, members are informed to call Enrollee Services (1-866-432-0001) on page 60 of the Member Handbook. *Quality Improvement Plan:* *•Remove the references to dental in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C.* *•The grievance acknowledgement timeframes listed in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document should be added to Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.* *•Correct the grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document as required by the SCDHHS Contract, Section 9.1.1.2.1.* *•Correct the grievance phone number listed in the Member Handbook, page 26.*
Humana Response: Humana has incorporated the referenced revisions. Please see the following: • HM4200 – 07012021 – Policy (South Carolina Medicaid Grievance First Level Review) – 001F at page 2 • HM4200 – 07012021 – Policy (South Carolina Medicaid Expedited Grievance First Level Review) – 001C • HM4200 – 07012021 – Policy (South Carolina Medicaid Grievance and Appeal Policy)-001 at page 4 • SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 at page 27 6/9 - For Line 19, we updated the QIP tool/response but did not submit any additional documents. All additional information we added to the QIP tool / chart is highlighted in yellow. Humana has incorporated the referenced revisions. Please see the following: • HM4200 – 07012021 – Policy (South Carolina Medicaid Grievance First Level Review) – 001F at page 2 • HM420– 07012021 – Policy (South Carolina Medicaid Expedited Grievance First Level Review) – 001C • HM4200 – 07012021 – Policy (South Carolina Medicaid Grievance and Appeal Policy)-001 at page 4 (last sentence of paragraph addressing 9.1.4.2) • SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 at page 27	

Figure 8: Member Services provides an overview of the plans' performance in the Member Services section.

Figure 8: Member Services



A comparison of the plans' scores for the standards in the Member Services section is illustrated in *Table 28: Member Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 28: Member Services Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities	Met	Met	Met	Met	Met	**Strengths:** ▶ Members are informed of their rights and responsibilities are in welcome materials, handbooks, websites, newsletters. ▶ Members are guaranteed all required rights.
All Member rights included	Met	Met	Met	Met	Met	
Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information	Met	Met	Met ↑	Met	Met ↑	**Strengths:** ▶ Health plans provide new member information in a variety of ways, including welcome packets, plan websites, newsletters, and Member Handbooks. Members may contact the Member Services call centers and 24-hour nurse lines for additional information and assistance. ▶ Appropriate processes are in place to notify members of changes in benefits and provider networks. ▶ The MCOs ensure member materials are written at appropriate grade levels for understanding and are available in alternate formats.
Members are notified at least once per year of their right to request a Member Handbook or Provider Directory	Met	Met	Met	Met	Met	
Members are informed in writing of changes in benefits and changes to the provider network	Met	Met	Met ↑	Met	Met	
Member program education materials are written in a clear and understandable manner and meet contractual requirements	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO	Met	Met	Met	Met	Met	**Weaknesses:** ▶ Humana's Member Handbook did not include full benefit information for chiropractic services, communicable disease services, newborn hearing screenings, rehabilitative therapies for children, BabyNet Services, and transplant services. **Recommendations:** • Ensure member materials include complete information about benefits to which members are entitled.
Member Enrollment and Disenrollment *42 CFR § 438.56*						
The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed	Met	Met	Met	Met	Met	
MCO-initiated member disenrollment requests are compliant with contractual requirements	Met	Met	Met	Met	Met	
Preventive Health and Chronic Disease Management Education						
The MCO informs members of available preventive health and disease management services and encourages members to utilize these services	Met	Met	Met	Met	Met	**Strengths:** ▶ The MCOs inform members of available preventive care programs, disease management programs, and wellness incentives. ▶ Members are encouraged to utilize preventive care services through call/text campaigns, flyers, newsletters, websites, call center staff, etc.
The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO provides education to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met	
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care	Met	Met	Met	Met	Met	
Member Satisfaction Survey						
The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to	Met	Met	Not Evaluated	Met	Met	**Strengths:** ▶ The MCOs conduct annual Member Satisfaction Surveys using certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors. ▶ The survey results are used to identify quality issues/opportunities for improvement and to implement strategies to address them. Results are reported to the plans' Quality Committees and to network providers. ▶ Healthy Blue's survey validation revealed that response rates for the Adult, Child, and Child with Chronic Conditions improved from the previous year's rates. **Weaknesses:** ▶ Member Satisfaction Survey response rates decreased for ATC, Molina, and Select Health. Of
Statistically sound methodology, including probability sampling to ensure it is representative of the total membership	Met	Met	Not Evaluated	Met	Met	
The availability and accessibility of health care practitioners and services	Met	Met	Not Evaluated	Met	Met	
The quality of health care received from MCO providers	Met	Met	Not Evaluated	Met	Met	
The scope of benefits and services	Met	Met	Not Evaluated	Met	Met	
Claim processing procedures	Met	Met	Not Evaluated	Met	Met	
Adverse MCO claim decisions	Met	Met	Not Evaluated	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The MCO analyzes data obtained from the member satisfaction survey to identify quality issues	Met	Met	Not Evaluated	Met	Met	note, ATC's rates have decreased for the last three review cycles. **Recommendations:** • Conduct barrier analyses to determine the issues with obtaining survey responses. Evaluate for additional methods to improve response rates, such as cover letter design, mode and timing of administration, and member awareness campaigns. Solicit ideas during workgroup meetings to determine other methods to enhance member responses to surveys.
The MCO implements significant measures to address quality issues identified through the member satisfaction survey	Met	Met	Not Evaluated	Met	Met	
The MCO reports the results of the member satisfaction survey to providers	Met	Met	Not Evaluated	Met	Met	
The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee	Met	Met	Not Evaluated	Met	Met	
Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to	Met	Met	Met	Met	Met	**Strengths:** ▶ Grievance processes and requirements are appropriately documented in policies, member and provider handbooks, and on health plan websites. ▶ The health plans ensure that clinical grievances and grievances related to the denial of expedited appeal resolution are reviewed by a Medical Director or an alternate physician designee. ▶ The health plans track, categorize and analyze grievances for trends, patterns, and opportunities
The definition of a grievance and who may file a grievance	Met	Met	Met	Met	Met	
Procedures for filing and handling a grievance	Met	Met	Met ↑	Met	Met	
Timeliness guidelines for resolution of a grievance	Met	Met	Met	Met	Met	
Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Maintenance and retention of a grievance log and grievance records for the period specified in the contract	Met	Met	Met	Met	Met	for improvement. Grievance data are routinely reported to appropriate Quality committees. ▶ Grievance files for ATC, Molina, and Select Health, identified no issues. **Weaknesses:** ▶ For Healthy Blue, grievance files reflected that the plan does not always follow its own policy regarding the timeframe for acknowledging grievances. Humana's grievance files revealed issues with the timeliness for sending acknowledgement letters, untimely grievance resolution, and not taking appropriate action to resolve a member's request for a list of PCPs in her area. **Recommendations:** • Review processes and timeliness standards for grievances and implement steps for performance improvement.
The MCO applies grievance policies and procedures as formulated	Met	Partially Met ↓	Partially Met	Met	Met	
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met	
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met	

D. Quality Improvement

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

MCOs are required to have an ongoing comprehensive quality assessment and performance improvement program for the services furnished to members. The Quality Improvement (QI) section of the EQR of the health plans in SC included review of the programs' structures, work plans, program evaluations, performance measure validation, and performance improvement project validation.

Each health plan provided a program description that explains the QI programs' structure, scope, goals, accountabilities, and resources. On an annual basis, the QI program descriptions are reviewed and updated as needed. During the previous year's Readiness Review for Humana, it was noted that the QI program description did not include the scope of work (see *Table 29: Humana's Previous EQR QI Program Deficiency and Response*). Humana updated the QI program description and addressed the scope of work.

Table 29: Humana's Previous EQR QI Program Deficiency and Response

Standard	EQR Comments
IV A. The Quality Improvement (QI) Program	
1. The MCO has a system in place for implementing a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	Humana provided the Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description, 2021. This program description provides the goals and objectives for the Healthy Horizon's program. Some of the goals included: developing clinical strategies and programs that look at the whole person and integrating behavioral and physical health. The QI Program Description does not address the scope of the program. Page eight of the program description, under letter E, Quality Assessment and Performance Improvement Program Scope, only mentions "Humana provides Medicaid covered services to eligible Medicaid beneficiaries as a qualified Health Maintenance Organization." The QI program description will be reviewed and updated at least annually. *Quality Improvement Plan: Update Section E of the QI Program Description and Include the program's scope.*
Humana Response: Humana has updated Section E of the QI Program Description to address the scope of the program. Please refer to the following document: HM4200 - 07012021 – Policy (2021 Humana SC MCD QAPI Program Description)-012 at page 8.	

Each health plan develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. The work plans are reviewed and updated at least quarterly. Any previously identified issues and

opportunities are addressed in the updates. The review of the work plans found some areas needed improvements. Molina's QI Work Plan was missing several goals for the provider appointment access audits. Humana's work plan was missing several goals for the 2022 activities. Healthy Blue's Contracts and Dashboards section of the 2021 work plan was blank. It did not include the benchmark/goal and did not record any quarterly updates.

A committee was established for each plan charged with oversight of the QI programs. The committees review data received from the QI activities to ensure performance meets standards and make recommendations as needed. Membership for the quality committees included the health plan's senior leadership, department directors and managers, and other plan staff. Network providers of varying specialties are included as voting members for all the health plans except Humana. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the quality oversight committee. Humana indicated recruitment efforts were underway to recruit providers to serve on their Quality Assurance Committee.

The health plans provide information and several resources about the QI Programs to members and practitioners via their websites and/or newsletters. Network providers are informed of their QI performance data on the practitioner's performance on key quality measures via provider report cards, gaps in care reports delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax. Molina provided two examples of the quality reports generated for providers. However, there was no documentation found regarding the process for how often these reports are generated and shared with providers. There was also no information found to inform network providers of the availability of these reports.

Humana uses the Stars Quality Report. During the Readiness Review, Humana policy regarding provider performance did not address Medicaid providers. This deficiency was addressed, and the policy corrected. See *Table 30: Humana's Previous EQR Deficiency and Response*.

Table 30: Humana's Previous EQR Deficiency and Response

Standard	EQR Comments
IV E. Provider Participation in Quality Improvement Activities	
2. Providers will receive interpretation of their QI performance data and feedback regarding QI activities.	Humana will use The Stars Quality Report, which provides a list of members in their care that have a known gap in care. The Stars Quality Report is delivered via in-person visits, self-service access to a provider reporting system, mail, and secure fax. Policy (NNO 702-040 Physician Performance Measurement)-007 contains the *SCDHHS Contract* references and lists the purpose of the policy as "This policy recognizes our strategic goals of continuously

Standard	EQR Comments
	improving the efficiency and effectiveness of our networks." Under the section labeled "Policy and Procedure," there is an embedded PDF file labeled NNO 702-040 Physician Performance. This embedded PDF file is Humana's corporate policy for improving the efficiency and effectiveness of commercial and Medicare Advantage networks. This policy does not address the Medicaid line of business. *Quality Improvement Plan: Update Policy (NNO 702-040 Physician Performance Measurement)-007 and include the specific for monitoring the SC providers performance.*
Humana Response: Humana updated the referenced policy to include the specific procedure for monitoring for SC providers performance (refer to redlined updates in HM4200 - 07012021 - Policy (NNO 702-040 Physician Performance Measurement)-007). In addition, Humana updated the supporting enterprise policy to indicate applicability to Medicaid (refer to HM4200 - 08122010 - Policy (NNO 702-040 Physician Performance Measurement) 007A- page 1). In addition to the Physician Performance Measurement documents, please refer to HUM4200 – 07212021-Policy (Medical Record Review)-013 and HM4200 - 05162013- Policy (Guidelines for Eval Clinical Practice Guidelines Adherence)-010B for details regarding to other provider monitoring processes.	

Each plan evaluates the overall effectiveness of the QI Program and reports the evaluation to the Board of Directors and to various Quality Improvement Committees. Each plan provided copies of the Annual Evaluations for review. Molina provided the Quality Improvement Program 2020 Medicaid Annual Evaluation. The evaluation was incomplete and did not include the results of all the QI activities conducted in 2019. The section in the Executive Summary regarding the focus for upcoming year incorrectly included the focus for 2022 instead of 2021. These errors and omissions were discussed during the onsite. Molina indicated those activities omitted from the program evaluation were conducted and provided copies of some of the reports after the onsite. However, these activities were not considered when the 2020 QI Program Evaluation was conducted.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Health plans are required to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the PMs reported, CCME uses the *CMS Protocol, Validation of Performance Measures*. This validation protocol balances the subjective and objective parts of the review, supports a review that is fair to the plans, and provides the State with information about how each plan is operating.

All plans are using a HEDIS® certified vendor or software to collect and calculate the measures, and all were found to be "Fully Compliant." Plan rates for the most recent review year are reported in *Table 31: HEDIS® Performance Measure Data for HEDIS 2020*.

The statewide average is calculated as the average of the plan rates and shown in the last column in the table. Rates highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease in the rate of more than 10 percent.

Table 31: HEDIS® Performance Measure Data for HEDIS MY2020

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Effectiveness of Care: Prevention and Screening					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)					
BMI Percentile	73.48%	75.00%	73.24%	79.15%	75.22%
Counseling for Nutrition	61.07%	63.66%	61.07%	69.10%	63.73%
Counseling for Physical Activity	57.18%	62.37%	56.69%	65.58%	60.46%
Childhood Immunization Status (cis)					
DTaP	69.59%	70.07%	74.45%	77.37%	72.87%
IPV	85.40%	86.13%	87.83%	91.24%	87.65%
MMR	86.13%	87.83%	89.05%	91%	88.50%
HiB	79.56%	82.00%	81.75%	87.35%	82.67%
Hepatitis B	83.70%	82.73%	83.94%	90.75%	85.28%
VZV	85.89%	86.62%	87.83%	90.51%	87.71%
Pneumococcal Conjugate	72.75%	73.72%	77.62%	82%	76.52%
Hepatitis A	83.94%	87.10%	86.13%	88.32%	86.37%
Rotavirus	70.07%	72.26%	76.89%	80.54%	74.94%
Influenza	41.36%	45.99%	40.63%	41.61%	42.40%
Combination #2	64.96%	64.72%	72.26%	74.21%	69.04%
Combination #3	63.26%	63.26%	71.05%	72.75%	67.58%
Combination #4	62.04%	63.02%	70.07%	72.51%	66.91%
Combination #5	55.96%	55.96%	63.75%	66.67%	60.59%
Combination #6	34.79%	35.04%	35.04%	37.47%	35.59%
Combination #7	55.23%	55.72%	62.77%	66.42%	60.04%
Combination #8	34.79%	35.04%	34.31%	37.47%	35.40%
Combination #9	31.14%	31.39%	32.85%	35.77%	32.79%
Combination #10	31.14%	31.39%	32.12%	35.77%	32.61%
Immunizations for Adolescents (ima)					
Meningococcal	70.56%	69.10%	74.45%	84.43%	74.64%
Tdap/Td	82.24%	79.08%	82.48%	91.97%	83.94%
HPV	31.63%	30.41%	33.33%	40.39%	33.94%
Combination #1	69.83%	68.86%	73.48%	83.21%	73.85%
Combination #2	29.93%	28.95%	32.60%	38.69%	32.54%
Lead Screening in Children (lsc)	67.85%	72.02%	70.33%	71.01%	70.30%
Breast Cancer Screening (bcs)	57.55%	51.00%	57.08%	58.48%	56.03%

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Cervical Cancer Screening (ccs)	59.61%	59.12%	58.15%	66.39%	60.82%
Chlamydia Screening in Women (chl)					
16-20 Years	59.98%	52.76%	57%	56.98%	56.68%
21-24 Years	63.92%	59.22%	63.40%	64.21%	62.69%
Total	61.34%	55.56%	59.16%	58.61%	58.67%
Effectiveness of Care: Respiratory Conditions					
Appropriate Testing for Pharyngitis (cwp)					
3-17 years	84.01%	86.18%	85.81%	85.85%	85.46%
18-64	73.42%	73.95%	72.36%	74.03%	73.44%
65+	50.00%	NA*	NA*	NA	NA
Total	81.69%	83.53%	82.56%	84%	82.95%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.44%	29.61%	26.19%	30.96%	28.55%
Pharmacotherapy Management of COPD Exacerbation (pce)					
Systemic Corticosteroid	69.26%	69.00%	71.09%	74.31%	70.92%
Bronchodilator	80.42%	78.05%	83.18%	86.90%	82.14%
Asthma Medication Ratio (amr)					
5-11 Years	81.77%	86.06%	76.79%	80.90%	81.38%
12-18 Years	75%	73.56%	65.81%	70.80%	71.29%
19-50 Years	49.66%	55.97%	47.78%	56.47%	52.47%
51-64 Years	48.24%	51.39%	48.09%	59.30%	51.76%
Total	70.89%	73.47%	64.50%	72.50%	70.34%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (cbp)	51.34%	48.18%	46.96%	53.53%	50.00%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.89%	77.14%	77.14%	79.10%	75.57%
Statin Therapy for Patients With Cardiovascular Disease (spc)					
Received Statin Therapy - 21-75 years (Male)	81.82%	77.18%	79.31%	82.06%	80.09%
Statin Adherence 80% - 21-75 years (Male)	62.57%	59.68%	62.80%	63.17%	62.06%
Received Statin Therapy - 40-75 years (Female)	79.19%	77.73%	80.65%	78.23%	78.95%
Statin Adherence 80% - 40-75 years (Female)	62.71%	58.54%	60.50%	63.48%	61.31%
Received Statin Therapy - Total	80.73%	77.43%	79.96%	80.07%	79.55%
Statin Adherence 80% - Total	62.63%	59.14%	61.67%	63.33%	61.69%
Cardiac Rehabilitation (CRE)					
Cardiac Rehabilitation - Initiation (18-64)	4.10%	1.14%	2.43%	3.67%	2.84%
Cardiac Rehabilitation - Engagement1 (18-64)	3.59%	0.57%	2.91%	2.86%	2.48%
Cardiac Rehabilitation - Engagement2 (18-64)	3.59%	0%	1.94%	2.04%	1.89%
Cardiac Rehabilitation - Achievement (18-64)	1.03%	0%	0%	0.41%	0.36%
Cardiac Rehabilitation - Initiation (65+)	9.52%	NA*	NR	NA*	9.52%
Cardiac Rehabilitation - Engagement1 (65+)	9.52%	NA*	NR	NA*	9.52%

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Cardiac Rehabilitation - Engagement2 (65+)	9.52%	NA*	NR	NA*	9.52%
Cardiac Rehabilitation - Achievement (65+)	9.52%	NA*	NR	NA*	9.52%
Cardiac Rehabilitation - Initiation (Total)	5.06%	1.14%	2.43%	3.67%	3.08%
Cardiac Rehabilitation - Engagement1 (Total)	4.64%	0.57%	2.91%	2.86%	2.75%
Cardiac Rehabilitation - Engagement2 (Total)	4.64%	0%	1.94%	2.04%	2.16%
Cardiac Rehabilitation - Achievement (Total)	2.53%	0%	0%	0.41%	0.74%
Effectiveness of Care: Diabetes					
Comprehensive Diabetes Care (cdc)					
Hemoglobin A1c (HbA1c) Testing	88.08%	84.43%	87.35%	84.67%	86.13%
HbA1c Poor Control (>9.0%)	44.04%	51.09%	49.39%	56.93%	50.36%
HbA1c Control (<8.0%)	47.69%	44.28%	41.85%	36.98%	42.70%
Eye Exam (Retinal) Performed	47.20%	35.52%	52.55%	43.31%	44.65%
Blood Pressure Control (<140/90 mm Hg)	52.55%	49.15%	55.23%	53.04%	52.49%
Kidney Health Evaluation for Patients With Diabetes (KED)					
Kidney Health Evaluation for Patients With Diabetes (18-64)	21.56%	21.93%	22.76%	23.14%	22.35%
Kidney Health Evaluation for Patients With Diabetes (65-74)	25.71%	NA*	NR	NA*	25.71%
Kidney Health Evaluation for Patients With Diabetes (75-85)	28.51%	NA*	NR	NA*	28.51%
Kidney Health Evaluation for Patients With Diabetes (Total)	23.31%	21.93%	22.76%	23.15%	22.79%
Statin Therapy for Patients With Diabetes (spd)					
Received Statin Therapy	66.85%	61.79%	64.29%	62.34%	63.82%
Statin Adherence 80%	59.59%	49.43%	58.33%	56.70%	56.01%
Effectiveness of Care: Behavioral Health					
Antidepressant Medication Management (amm)					
Effective Acute Phase Treatment	48.30%	49.78%	51.88%	47.21%	49.29%
Effective Continuation Phase Treatment	32.07%	33.59%	34.80%	30.90%	32.84%
Follow-Up Care for Children Prescribed ADHD Medication (add)					
Initiation Phase	44.63%	36.55%	56.23%	45.30%	45.68%
Continuation and Maintenance (C&M) Phase	63.28%	46.91%	66.34%	60.30%	59.21%
Follow-Up After Hospitalization for Mental Illness (fuh)					
6-17 years - 30-Day Follow-Up	74.02%	71.70%	77.42%	78.35%	75.37%
6-17 years - 7-Day Follow-Up	50.89%	52.09%	57.26%	53.87%	53.53%
18-64 years - 30-Day Follow-Up	54.60%	53.66%	53.17%	56.35%	54.45%
18-64 years - 7-Day Follow-Up	33.09%	32.77%	30.19%	35.67%	32.93%
65+ years - 30-Day Follow-Up	NA	NA*	NA*	NR*	NA
65+ years - 7-Day Follow-Up	NA	NA*	NA*	NR*	NA
30-Day Follow-Up	60.69%	59.46%	61.75%	69.01%	62.73%
7-Day Follow-Up	38.50%	38.99%	39.77%	46.14%	40.85%

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Follow-Up After Emergency Department Visit for Mental Illness (fum)					
6-17 years - 30-Day Follow-Up	70.76%	66.82%	71.74%	73.18%	70.63%
6-17 years - 7-Day Follow-Up	55.56%	47.47%	56.52%	58.52%	54.52%
18-64 years - 30-Day Follow-Up	42.70%	43.80%	45.04%	45.26%	44.20%
18-64 years - 7-Day Follow-Up	27.81%	31.13%	29.75%	32.48%	30.29%
65+ years - 30-Day Follow-Up	NA	NA	NA*	NR*	NA
65+ years - 7-Day Follow-Up	NA	NA	NA*	NR*	NA
30-Day Follow-Up	51.93%	52.41%	54.19%	60.84%	54.84%
7-Day Follow-Up	37.06%	37.24%	38.92%	47.01%	40.06%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)					
13-17 years - 30-Day Follow-Up	NA	25%	33.33%	32.65%	30.33%
13-17 years - 7-Day Follow-Up	NA	12.50%	20%	16.33%	16.28%
18-64 years - 30-Day Follow-Up	42.64%	35.75%	43.62%	41.92%	40.98%
18-64 years - 7-Day Follow-Up	23.35%	25.12%	29.79%	29.34%	26.90%
65+ years - 30-Day Follow-Up	NA	NA*	NA*	NR*	NA
65+ years - 7-Day Follow-Up	NA	NA*	NA*	NR*	NA
Total - 30-Day Follow-Up	40%	35.35%	42.86%	40.73%	39.74%
Total - 7-Day Follow-Up	22.67%	24.65%	29.06%	27.68%	26.02%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)					
13-17 years - 30-Day Follow-Up	NA	12.12%	12.90%	8.18%	11.07%
13-17 years - 7-Day Follow-Up	NA	6.06%	9.68%	5.45%	7.06%
18+ years - 30-Day Follow-Up	12.50%	17.52%	16.48%	18.14%	16.16%
18+ years - 7-Day Follow-Up	9.25%	12.61%	11.21%	12.20%	11.32%
Total - 30-Day Follow-Up	12.29%	17.17%	16.24%	16.71%	15.60%
Total - 7-Day Follow-Up	8.98%	12.18%	11.11%	11.23%	10.88%
Pharmacotherapy for Opioid Use Disorder (pod)					
16-64 years	40.94%	40.89%	24.26%	47.21%	38.33%
65+ years	NA*	NA*	NA*	NA*	NA
Total	40.31%	40.89%	24.39%	47.21%	38.20%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	75.13%	74.27%	74.31%	74.26%	74.49%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	66.29%	59.76%	66.16%	66.56%	64.69%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	NA*	60.00%	NA*	66.67%	63.34%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	63.81%	60.00%	72.39%	66.67%	65.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)					
Blood glucose testing - 1-11 Years	32.12%	37.39%	33.64%	40.27%	35.86%
Cholesterol Testing - 1-11 Years	21.90%	29.57%	24.55%	30.20%	26.56%

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Blood glucose and Cholesterol Testing - 1-11 Years	21.17%	26.96%	21.82%	28.16%	24.53%
Blood glucose testing - 12-17 Years	56.41%	50.00%	50.34%	58.95%	53.93%
Cholesterol Testing - 12-17 Years	30.77%	22.43%	28.86%	39.19%	30.31%
Blood glucose and Cholesterol Testing - 12-17 Years	29.74%	21.50%	27.52%	37.41%	29.04%
Blood glucose testing - Total	46.39%	45.59%	45.83%	52.94%	47.69%
Cholesterol Testing - Total	27.11%	24.92%	27.70%	36.30%	29.01%
Blood glucose and Cholesterol Testing - Total	26.20%	23.40%	25.98%	34.43%	27.50%
Effectiveness of Care: Overuse/Appropriateness					
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.46%	0.61%	0.64%	0.70%	0.85%
Appropriate Treatment for Children With URI (uri)					
3 months-17 Years	62.44%	88.55%	88.42%	87.64%	81.76%
18-64 Years	33.92%	72.36%	69.30%	70.99%	61.64%
65+ Years	16.33%	NA*	NA*	NA*	NA
Total	52.92%	86.36%	85.50%	85.87%	77.66%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)					
3 months-17 Years	62.44%	59.98%	58.65%	51.59%	58.17%
18-64 Years	33.92%	31.12%	28.34%	28.74%	30.53%
65+ Years	16.33%	NA*	NA*	NA*	NA
Total	52.92%	51.18%	48.28%	45.42%	49.45%
Use of Imaging Studies for Low Back Pain (lbp)	69.25%	70.77%	68.74%	73.16%	70.48%
Use of Opioids at High Dosage (hdo)	2.49%	3.41%	2.51%	4.31%	3.18%
Use of Opioids From Multiple Providers (uop)					
Multiple Prescribers	15.40%	20.06%	20.44%	18.68%	18.65%
Multiple Pharmacies	3.33%	3.25%	4.14%	5.59%	4.08%
Multiple Prescribers and Multiple Pharmacies	1.35%	1.95%	2.42%	2.59%	2.08%
Risk of Continued Opioid Use (cou)					
18-64 years - >=15 Days covered	4.07%	4.00%	4.79%	2.05%	3.73%
18-64 years - >=31 Days covered	1.90%	3.10%	3.13%	0.94%	2.27%
65+ years - >=15 Days covered	14.81%	NA	NA*	NA*	NA
65+ years - >=31 Days covered	8.13%	NA	NA*	NA*	NA
Total - >=15 Days covered	5.38%	4%	4.79%	2.05%	4.06%
Total - >=31 Days covered	2.66%	3.10%	3.13%	0.94%	2.46%
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (aap)					
20-44 Years	75.13%	74.75%	77.29%	78.40%	76.39%
45-64 Years	83.35%	83.61%	87.21%	87.33%	85.38%
*65+ Years**	89.59%	100%	NA*	80.00%	89.86%
Total	79.56%	76.80%	80.24%	80.42%	79.26%

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Initiation and Engagement of AOD Dependence Treatment (iet)					
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	39.29%	NA*	42.48%	40.89%
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	10.71%	NA*	8.85%	9.78%
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	NA*	NA*	73.68%	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	NA*	NA*	42.11%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	42.11%	42.24%	48.44%	39.09%	42.97%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	10.53%	10.34%	16.41%	12.33%	12.40%
Initiation of AOD Treatment: 13-17 Years	40.28%	39.85%	46.04%	38.84%	41.25%
Engagement of AOD Treatment: 13-17 Years	9.72%	9.77%	15.11%	12.27%	11.72%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	45.49%	41.88%	41.44%	36.97%	41.45%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	7.14%	6.57%	6.58%	6.62%	6.73%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	59.36%	56.79%	57.87%	61.93%	58.99%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	31.53%	35.41%	33.33%	37.93%	34.55%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	43.04%	40.78%	42.72%	37.64%	41.05%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	9.22%	9.44%	7.90%	6.80%	8.34%
Initiation of AOD Treatment: 18+ Years	45.41%	43.85%	43.86%	41.78%	43.73%
Engagement of AOD Treatment: 18+ Years	12.13%	13.80%	11.62%	12.84%	12.60%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	45.32%	41.79%	41.81%	37.48%	41.60%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7%	6.72%	6.87%	6.83%	6.86%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	59.46%	56.29%	58.09%	62.25%	59.02%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	31.45%	35.10%	33.16%	38.04%	34.44%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	42.93%	40.92%	43.30%	37.96%	41.28%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	9.37%	9.52%	8.77%	8.01%	8.92%
Initiation of AOD Treatment: Total	45.08%	43.61%	44.01%	41.32%	43.51%
Engagement of AOD Treatment: Total	11.97%	13.56%	11.85%	12.75%	12.53%
Prenatal and Postpartum Care (ppc)					
Timeliness of Prenatal Care	89.54%	87.59%	92.70%	88.79%	89.66%
Postpartum Care	76.89%	78.10%	74.45%	75.00%	76.11%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)					
1-11 Years	51.79%	58.97%	56.41%	60.39%	56.89%
12-17 Years	54.88%	67.19%	62.00%	63.71%	61.95%

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Total	53.62%	64.08%	60.43%	62.52%	60.16%
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)	50.75%	47.33%	57.00%	59.87%	53.74%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	69.74%	71.17%	72.56%	77.07%	72.64%
Child and Adolescent Well-Care Visits (WCV)					
Child and Adolescent Well-Care Visits (3-11)	47.26%	47.01%	48.49%	52.86%	48.91%
Child and Adolescent Well-Care Visits (12-17)	43.20%	40.23%	45.24%	48.02%	44.17%
Child and Adolescent Well-Care Visits (18-21)	20.36%	17.48%	22.63%	23.56%	21.01%
Child and Adolescent Well-Care Visits (Total)	43.17%	41.90%	44.03%	47.94%	44.26%

Note. NR= not reported; NA= not applicable due to low denominator or missing data

The comparison of rates from MY2019 to MY2020 highlighted in green showed a substantial improvement of more than 10 percent year over year. The rates highlighted in red indicate a substantial decrease of more than 10 percent. *Table 32* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 32: HEDIS measures with Substantial Increases or Decreases

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Effectiveness of Care: Prevention and Screening					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)					
BMI Percentile	73.48%	75.00%	73.24%	79.15%	75.22%
Counseling for Nutrition	61.07%	63.66%	61.07%	69.10%	63.73%
Counseling for Physical Activity	57.18%	62.37%	56.69%	65.58%	60.46%
Effectiveness of Care: Respiratory Conditions					
Appropriate Testing for Pharyngitis (cwp)					
65+	50.00%	NA*	NA*	NA	NA
Pharmacotherapy Management of COPD Exacerbation (pce)					
Systemic Corticosteroid	69.26%	69.00%	71.09%	74.31%	70.92%
Asthma Medication Ratio (amr)					
19-50 Years	49.66%	55.97%	47.78%	56.47%	52.47%
51-64 Years	48.24%	51.39%	48.09%	59.30%	51.76%
Effectiveness of Care: Cardiovascular Conditions					
Controlling High Blood Pressure (cbp)	51.34%	48.18%	46.96%	53.53%	50.00%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	68.89%	77.14%	77.14%	79.10%	75.57%
Statin Therapy for Patients With Cardiovascular Disease (spc)					

MEASURE/DATA ELEMENT	ATC	Healthy Blue	Molina	Select Health	Statewide Average
Statin Adherence 80% - 21-75 years (Male)	62.57%	59.68%	62.80%	63.17%	62.06%
Statin Adherence 80% - 40-75 years (Female)	62.71%	58.54%	60.50%	63.48%	61.31%
Statin Adherence 80% - Total	62.63%	59.14%	61.67%	63.33%	61.69%
Effectiveness of Care: Diabetes					
Comprehensive Diabetes Care (cdc)					
HbA1c Poor Control (>9.0%)	44.04%	51.09%	49.39%	56.93%	50.36%
Eye Exam (Retinal) Performed	47.20%	35.52%	52.55%	43.31%	44.65%
Statin Therapy for Patients With Diabetes (spd)					
Statin Adherence 80%	59.59%	49.43%	58.33%	56.70%	56.01%
Effectiveness of Care: Behavioral Health					
Follow-Up After Hospitalization for Mental Illness (fuh)					
6-17 years - 7-Day Follow-Up	50.89%	52.09%	57.26%	53.87%	53.53%
Follow-Up After Emergency Department Visit for Mental Illness (fum)					
6-17 years - 7-Day Follow-Up	55.56%	47.47%	56.52%	58.52%	54.52%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)					
13-17 years - 30-Day Follow-Up	NA	25%	33.33%	32.65%	30.33%
13-17 years - 7-Day Follow-Up	NA	12.50%	20%	16.33%	16.28%
18-64 years - 30-Day Follow-Up	42.64%	35.75%	43.62%	41.92%	40.98%
18-64 years - 7-Day Follow-Up	23.35%	25.12%	29.79%	29.34%	26.90%
Total - 30-Day Follow-Up	40%	35.35%	42.86%	40.73%	39.74%
Total - 7-Day Follow-Up	22.67%	24.65%	29.06%	27.68%	26.02%
Pharmacotherapy for Opioid Use Disorder (pod)					
16-64 years	40.94%	40.89%	24.26%	47.21%	38.33%
Total	40.31%	40.89%	24.39%	47.21%	38.20%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)					
Blood glucose testing - 1-11 Years	32.12%	37.39%	33.64%	40.27%	35.86%
Cholesterol Testing - 12-17 Years	30.77%	22.43%	28.86%	39.19%	30.31%
Access/Availability of Care					
Initiation and Engagement of AOD Dependence Treatment (iet)					
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	59.36%	56.79%	57.87%	61.93%	58.99%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	31.53%	35.41%	33.33%	37.93%	34.55%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	59.46%	56.29%	58.09%	62.25%	59.02%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	31.45%	35.10%	33.16%	38.04%	34.44%

ATC demonstrated a substantial increase in five measures. Those measures include Follow-Up After Emergency Department Visit for Mental Illness (fum)-6-17 years – 7-Day Follow-Up, Initiation and Engagement of AOD Dependence Treatment (iet)-Opioid abuse

or dependence, Initiation of AOD Treatment18+ Years, Opioid abuse or dependence, Engagement of AOD Treatment: 18+ Years, Opioid abuse or dependence: Initiation of AOD Treatment: Total, and Opioid abuse or dependence: Engagement of AOD Treatment: Total. There were eight measures that declined.

Healthy Blue had a substantial increase in six measures. Those included: Pharmacotherapy Management of COPD Exacerbation (pce) -Systemic Corticosteroid, Follow-Up After Hospitalization for Mental Illness (fuh)-6-17 years – 7-Day Follow-Up, Pharmacotherapy for Opioid Use Disorder (pod)-16-64 years -Total, Initiation and Engagement of AOD Dependence Treatment (iet)-Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years and Opioid abuse or dependence: Engagement of AOD Treatment: Total. One measure showed a substantial decline in the rate.

Molina also improved the HEDIS rate for five measures. Those included: Persistence of Beta-Blocker Treatment After a Heart Attack (pbh), Statin Therapy for Patients With Cardiovascular Disease (spc)-Statin Adherence 80%: 21-75 Years (Male), Statin Therapy for Patients With Cardiovascular Disease (spc)-Statin Adherence 80%: 40-75 Years (Female), Statin Therapy for Patients With Cardiovascular Disease (spc)-Statin Adherence 80%: Total, and Statin Therapy for Patients With Diabetes (spd)-Statin Adherence 80%. There were five measures that showed a substantial decline in the rate.

Select Health had improvements in four HEDIS measures. Those included Pharmacotherapy Management of COPD Exacerbation (pce) – Systemic Corticosteroid, Asthma Medication Ratio (amr) – 51-64 Years, and Pharmacotherapy for Opioid Use Disorder (pod) – 16-64 years and the Total. There were five measures that showed a decline in the rates.

Humana did not provide performance measures for validation. Per onsite discussion, Humana expects to have reported rates next year.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, *EQR Protocol 1: Validation of Performance Improvement Projects, October 2019*. The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

- Improvement strategies

Nine projects were validated for four plans. Results of the validation, the project status, and interventions for each project are displayed in the tables that follow.

For this review ATC submitted two PIPs: Provider Satisfaction and Hospital Readmissions. Both met the all the validation requirements and scored in the "High Confidence in Reported Results" range. The reported rates for the provider satisfaction and readmission PIP showed improvements in the rates and interventions were effective. The table that follows provide an overview of the previous validation scores with the current scores. A summary of each PIP's status and the interventions are also included.

Table 33: Absolute Total Care PIP Validation Results

Provider Satisfaction	
The objective for the Provider Satisfaction project is to identify opportunities and implement initiatives to positively impact provider satisfaction and meet or exceed the plan's goal of the 75th percentile as defined by the SPH Analytics Medicaid Book of Business. The 2018, 2019, and 2020 rates were included in the PIP report for Overall Satisfaction with Absolute Total Care showing a reduction from 73.4% in 2018 to 57.9% in 2019 which then improved to 68% in 2020. This is below the goal rate of 75th percentile for Book of Business.	
Previous Validation Score	**Current Validation Score**
87/88=99% High Confidence in Reported Results	100/100=100% High Confidence in Reported Results
Interventions	
• Monthly roster updates and quarterly batch loads serves to mitigate provider abrasion with inaccurate enrollment data which causes claims payment inaccuracy. • Workgroup meetings to review and expedite claims adjustments and claims reconsiderations. • Robust training and orientation for Provider Relations and Customer Service Representatives. Leads from other functional areas attend team meetings to present on their scope and processes to familiarize the staff on additional business functions. • Provider education with quarterly virtual Town Hall meetings and developing and distributing educational materials on the provider portal and online tools to include how to access the formulary.	
Hospital Readmissions	
The health plan's overall rate for readmissions for the previous twelve months was 18.0% with several months during that period having a rate greater than 18.0%. After analysis of the data, ATC's department leaders and QIC identified an opportunity for improvement in reducing readmissions and a PIP was approved. The goal set internally for this PIP is to reduce the readmission rate to 17.5%. Data were reported for the baseline and Remeasurement 1. The results show a decline in readmissions from 18% to 16.2% in the 2020/2021 measure. These results indicate improvement in reducing readmission and exceed the goal rate of 17.5%.	
Previous Validation Score	**Current Validation Score**

72/72=100% High Confidence in Reported Results	80/80= 100% High Confidence in Reported Results
Interventions	
• Transition of Care (TOC) team assesses members upon discharge and reviews the discharge summary, assists member with scheduling appointment within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmission. Quarterly meetings with managers and the TOC team to discuss the TOC process. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • Members at risk for readmission based on most frequently admitted diagnosis are referred to the Case Manager or to Intensive Care Coordination for outreach if not actively enrolled in case management. • Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meet quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. • UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met.	

Healthy Blue submitted two PIPs for validation: The Comprehensive Diabetes Care PIP and a new PIP, CAHPS – Child with Chronic Conditions Customer Service PIP. The PIPs met the validation requirements and received scores within the "High Confidence Range." The table that follows provide an overview of the previous validation scores with the current scores and a summary of interventions for each project.

Table 34: Healthy Blue PIP Validation Results

Comprehensive Diabetes Care	
The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. Both indicators showed baseline rates. The HbA1C >9% rate was 51.09% with a goal of 58.75%. The Retinal eye exam indicator rate was 35.35% with a goal of 37.35%.	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	93/93= 100% High Confidence in Reported Results
Interventions	

• Targeted text messages outreach calls to members who have been diagnosed as being Diabetic to ensure that the member has their HbA1c screenings and Diabetic Retinal Eye Exams. • Members that become compliant on the following services- A1c test, eye exam and completion of diabetes survey will be able to choose gift cards from various platforms. In-addition to gift cards; members can receive fresh fruits and veggies. • Practice Consultants visit (webinars) providers, review their current Gap in Care, provide a PowerPoint presentation with HEDIS information, and answer any questions that the provider may have. • Case Managers offer members assist with PCP appointments, pharmacy, and any SDOH needs.
CAHPS - Child with Chronic Conditions Customer Service
This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass. It was noted the current interventions seem focused on improving response rates and reaching a larger audience, but not necessarily improving customer service scripts or resources.

Previous Validation Score	Current Validation Score
Not Submitted	88/93= 95% High Confidence in Reported Results
Interventions	
• Oversampling • Provide a Spanish Survey	

It was noted the current interventions for the CAHPS – Child with Chronic Conditions Customer Service PIP seem focused on improving response rates and reaching a larger audience, but not necessarily improving customer service scripts or resources. It was recommended that Healthy Blue revise this PIP and direct the interventions at improving customer service.

Last year, Molina submitted three PIPS: Well Care Visits, Breast Cancer Screenings, and the Correlation for Member Assignment and Engagement. The Correlation for Member Assignment and Engagement PIP scored in the "Confidence Range." The interventions that align with specific data barriers were not presented in the PIP report. Molina addressed those deficiencies and updated the PIP report. *Table 35: Molina's Previous EQR Quality Improvement Project Deficiencies* and Response provides an overview of the deficiencies and Molina's response.

Table 35: Molina's Previous EQR Quality Improvement Project Deficiencies and Response

Standard	EQR Comments
IV D. Quality Improvement Projects	

Standard	EQR Comments
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	
Performance Improvement Projects: Correlation between Member Assignment and Engagement	
Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions are not clearly documented in the report. *Recommendation: Display the specific data and system issues and aligned interventions to address those issues in the PIP report.*
Molina Response: The PIP report has been updated to include the corrections as indicated.	
Was there any documented, quantitative improvement in processes or outcomes of care?	Indicator one remained the same at 32%. Indicator two declined from 72% to 66%, and the goal is to increase that rate. Indicator three decreased from 85% to 47% and this is improvement, as the goal is to decrease indicator three. *Recommendation: Add interventions that are related to each indicator's barriers/data issues in efforts to improve rates.*
Molina Response: The PIP report has been updated to include the corrections as indicated.	

For this EQR, Molina implemented two new PIPs (Improving Encounters Acceptance Rates and Immunizations for Adolescents) and modified the Child and Adolescent Well-Care Visits Program PIP with a new indicator and baseline data. The PIPs met the validation requirements and received scores within the "High Confidence Range." The table that follows provides an overview of the previous validation scores with the current scores and a summary of interventions for each project.

Table 36: Molina's PIP Validation Results

Improving Encounters Acceptance Rates	
The focus for this PIP is to improve the encounter acceptance rates for professional (837P) encounters. This PIP has two indicators. The initial acceptance rate was 97.5% at baseline and declined to 96.9% at year 1 with a goal of 100%. For the 837P taxonomy rejection rate, the baseline was 2.63% and increased to 2.82%. The target goal for this indicator was set at 2%. Both indicators did not show improvement. It was recommended that Molina continue to monitor the indicator rates to determine if logic adjustment and rejected encounter reviews improve the rates toward 100% for initial acceptance rate.	
Previous Validation Score	**Current Validation Score**
Not Submitted	73/74=99% High Confidence in Reported Results
Interventions	

The interventions included a provider crosswalk, review of QNXT claims setup, logic checks, review of rejected encounters, and logic adjustment focusing on billing NPI.

Child and Adolescent Well-Care Visits Program	
Molina is implementing the Child and Adolescent Well-Care Visits Program to offer eligible Members and Providers incentives for Members receiving a Well-Visit or Comprehensive Well-Visit (for Ages 3 to 21). The baseline measurement rate for this PIP was 43.16%. using the administrative data. The interventions included member and provider education and outreach, incentive programs, and transportation assistance.	
Previous Validation Score	**Current Validation Score**
80/80=100% High Confidence in Reported Results	72/72=100% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with LogistiCare for Member Transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate Provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was Developed and Placed on the Provider Portal. • Calendar Year 2021 Member Incentive Mailing - Mailing to remind members that they are due for a well care visit and notify members of a $25 Walmart gift card incentive.	

Immunizations for Adolescents Program	
Molina chose this PIP to target rural and urban areas across SC to improve adolescent immunization rates and reduce vaccine preventable diseases and HPV-related cancers. The baseline rate for this PIP was reported as 27.98%.	
Previous Validation Score	**Current Validation Score**
Not Submitted	72/72=100% High Confidence in Reported Results
Interventions	
• Health Educator Team - Educates members on the incentive program, the importance of preventative well care visits, and the coordination, scheduling, and follow-up of appointments with the member's PCP. • Collaboration with LogistiCare for Member Transportation. • Development of Provider HEDIS Tip Sheets to discuss strategies and tips to educate Provider groups on HEDIS Measures. • HEDIS Missing Services Report/Gaps in Care Report Module was Developed and Placed on the Provider Portal. • Implementation of Mosaic, an internal Molina tool that aggregates member phone numbers from several sources to assist various teams in reaching unable to contact members.	

For this review, Select Health submitted two PIPs for validation. Topics for the PIPs included Diabetes Outcomes and Well-Care Visits for the Foster Care Population. Both PIPs met the validation requirements and scored in the "High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and the interventions are also included.

Table 37: Select Health's PIP Validation Results

Comprehensive Diabetes Care Outcomes Measures	
The aim for the diabetes PIP is to lower the HbA1c levels by providing additional education and outreach specifically on blood sugar control strategies, covered benefits, member incentives, and reminders for follow-up appointments to members who are in the poor control group (members whose lab results are available through data exchange and HbA1c levels are not <8). The Comprehensive Diabetes Care control measure A1c slightly improved while the BP measure continued to trend negatively in 2020. Both measures were impacted by the COVID-19 pandemic and did not meet the plan's goal for the 75th percentile. A1c <8 measure showed a 3.56% increase from the previous year and met the plan's goal of a 2% increase. The slight improvement in the A1c <8 measure may be a result of increase in data exchange and increase use of the Category-ll codes. The plan has implemented a flat file data exchange with supplemental reports for providers and increased overall EMR remote access to effectuate a year-round medical record review program. The blood pressure control measure demonstrated an 8.04% decline and did not meet the goal. The member incentives continued and resulted in a less than 1% return rate and therefore did not indicate an improvement. The results of this PIP would indicate that the incentive intervention was not effective. However, with the other confounding factors, the rates cannot be made and interventions will be continued in 2021. The HbA1c <8% improved from 35.71% to 36.98% The BP Control (<140/90) did not improve. The rate decreased from 57.68% to 53.04%. These recommendations were offered, continue interventions to improve rates by addressing member and provider barriers. Determine if analysis should focus primarily on the blood pressure control rate through the data sharing and MRR review interventions.	
Previous Validation Score	**Current Validation Score**
84/85=99% High Confidence in Reported Results	90/91= 99% High Confidence in Reported Results
Interventions	
• Fall/Winter 2020 Newsletter Article: "How the A1c test can help you manage diabetes." • HbA1c testing gift card incentive voucher mailed to 466 members. • Implemented a flat file data exchange with supplemental reports for providers. • Control measures added to value-based programs (i.e., PCP-QEP, FQHC-QEP, and large hospital systems). These programs were in development in 2018, expanded for 2019, and continue to expand in 2020. • Continued use of Category-ll codes and exploring more options for data exchange with direct EMR access. • The plan is currently working with lab vendors for monthly data file exchanges. • Virtual provider training and quality meetings were conducted throughout the year. • Spring-2020 Newsletter Article: "What is medicine adherence?"	
Well-Care Visits for Children and Adolescents in Foster Care in South Carolina	

The aim for the Well-Care Visits for Children and Adolescents in Foster Care PIP is to increase the compliance with well-care visits for the children and adolescents in the foster care. During the pilot project, Select Health found there was no defined process point for sharing health, behavioral health, dental history, or detail prior to placement and no process for sharing information between Select Health and SC Department of Social Services (SCDSS) while the child is in placement. Another significant finding of the Health Care Pilot and Case Process Review was that, despite the fact that virtually all children whose cases were reviewed received necessary health care and Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) well-child visits, there was not a user-friendly and systematic way to enter, measure, and identify or track action items needed for follow up that resulted from those visits. Two of three (66%) well-child visit measures demonstrated improvement from the CY2019 baseline year: Adolescent Well-Care Visit (awc) and Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34). One of three (33%) well-child visit measures, Well-Child Visits in the First 15 Months of Life (w15) 6+ Visits, experienced a small decrease from the CY2019 baseline year. All three measures (awc, w15, and w34) experienced substantial improvements from CY2018 to CY2020 – 5.94 percentage points, 3.37 percentage points, and 9.43 percentage points, respectively. The wcv is a new measure for this PIP. Baseline rates were presented for 3-11 years, 12-17 years, 18-21 years, and total.

Previous Validation Score	Current Validation Score
83/83=100% High Confidence in Reported Results	91/91=100% High Confidence in Reported Results

Interventions

- Data mapping corrections: Select Health, SCDSS, and SCDHHS will convene numerous times each year to assess the need to refresh, modify, update, and/or adjust the operational process-flows illustrated within the data maps.
- Foster Care Program Implementation.
- Rounds: Select Health Medical Directors will coordinate with SCDSS to perform clinical rounds on members.
- Establishment of a SCDSS and Select Health Operations Team (facilitated by SCDSS): Workgroups and subcommittees have been created to increase collaboration among all parties and to help support the operational needs of the new program.
- Data Sharing/Exchange, Analysis and Reporting: The SCDSS nightly data feed rosters of children in care is sent to SCDHHS to certify Medicaid eligibility and then on to Select Health who can then begin providing comprehensive assessments, well-child care, needed follow-up services and care management as needed. Additionally, Select Health has begun to produce gap-in-care reports to track utilization and care gaps, care management rosters, and other necessary information for SCDSS managers and field staff. A formal data-sharing agreement was fully executed in 2020 and will be assessed frequently for completeness, utility, and modifications based on relevant needs and technical parameters. Ad hoc report requests are submitted by SCDSS and fulfilled by SHSC under the *SCDHHS 2018 MCO Contract* provisions.
- Member & Provider Data Portal Access for SCDSS Staff: Select Health will create a special user type for SCDSS Staff to access and use the NaviNet Provider Portal. Use of this resource will allow SCDSS Staff the ability to access member-level data for Foster Care members only.

Humana did not submit any projects for validation. Per onsite discussion, the health plan is reviewing baseline data, other data sources, and forming work groups to begin discussions regarding topics for performance improvement projects. Per Policy (PIP) HUM-

SC-MCD-QM-002-01, the Quality Director will work with Medicaid and Quality Improvement leadership to develop meaningful topics that consider the prevalence of a condition in the member population. As a result of a previous deficiency (see *Table 38: Humana's Previous EQR Deficiency and Response*), this policy was updated to include the details of how the performance improvement project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project.

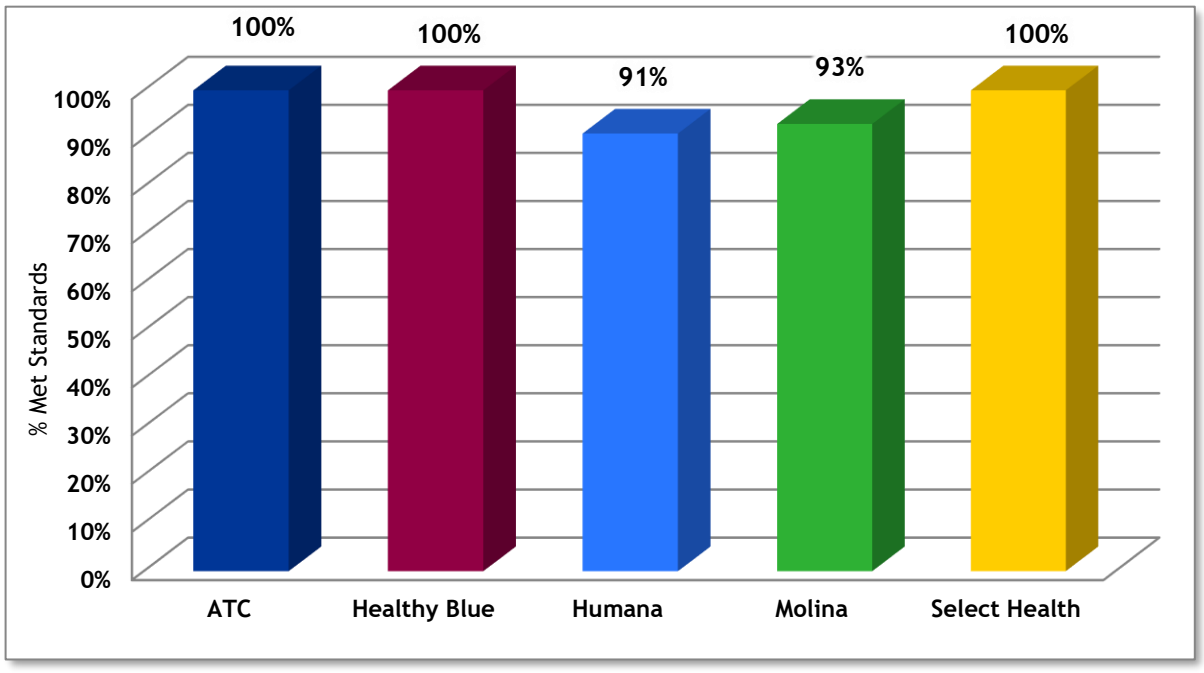
Table 38: Humana's Previous EQR PIP Deficiency and Response

Standard	EQR Comments
IV D. Quality Improvement Projects	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	Per Policy (PIP) HUM-SC-MCD-QM-002-01, the Quality Director will work with Medicaid and Quality Improvement leadership to develop meaningful topics that considers the prevalence of a condition in the member population. This policy fails to include the details of how the performance improvement project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project. *Quality Improvement Plan: Update policy HUM-SC-MCD-QM-002-01 to include details regarding how performance improvement project topics are developed or selected, data sources, and the steps needed for approval.*
Humana Response: Humana has updated its HUM-SC-MCD-QM-002-01 policy, "Performance Improvement Projects," to add details regarding the development and selection of performance improvement project topics, data sources, and approval steps. Please refer to the following document: HM4200 - 07012021 - Policy (Performance Improvement Projects)-004	

Humana submitted the template they plan to use to document performance improvement projects. CCME reviewed the template and noted that the template included all required CMS Protocol elements.

Overall, the plans performed well in the QI section. *Figure 9: Quality Improvement* provides an overview of the plans' performance in the QI section. Humana had weaknesses with their QI Committee, and there were no PIPs or performance measures available for validation. Molina's lower score was related to the QI Program Evaluation did not meet all the requirements.

Figure 9: Quality Improvement



A comparison of the plans' scores for the standards in the Quality Improvement section is illustrated in *Table 39: Quality Improvement Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care

Table 39: Quality Improvement Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	Met	Met ↑	Met	Met	**Strengths:** ▶ Each health plan has developed a QI program description that explains the QI programs' structure, scope, goals, accountabilities, and resources. On an annual basis the QI program descriptions are reviewed and updated as needed.
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met	
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Met	Met	
Quality Improvement Committee						
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met	**Weaknesses:** ▶ Humana's Quality Assurance Committee did not include a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*. **Recommendations:** • Health plans should recruit a variety of participating network providers to serve as members of the Quality Committee(s).
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Partially Met ↓	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The QI Committee meets at regular quarterly intervals	Met	Met	Met	Met	Met	
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met	Met	
Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures"	Met	Met	Not Evaluated	Met	Met	**Strengths:** ▶ Across the four MCOs reporting HEDIS rates, 20 measures showed substantial improvement from MY2019 to MY2020. **Weaknesses:** ▶ Across the four MCOs reporting HEDIS rates, 19 measures showed substantial decline from MY2019 to MY2020. **Recommendations:** • Monitoring interim administrative rates when available for HEDIS measures that have declined in the past year's trending analysis to determine if trend is consistent and in need of intervention.

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Met	Met	Not Evaluated	Met	Met	**Strengths:** ▶ Four the of five MCOs have performance improvement projects underway aimed at improving the care their members receive. Topics included postpartum care, diabetes, member satisfaction, immunizations, and well-care visits. Additional PIPs are focused on accuracy of encounter data and provider satisfaction. ▶ All the PIPs validated received a score within the High Confidence Range. **Weaknesses:** ▶ Humana did not have any performance improvement projects planned or underway. **Recommendations:** • Humana should continue the review of baseline data and convene work groups so topics for performance improvement projects can be developed.
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Met	Met	Not Evaluated	Met ↑	Met	
Provider Participation in QI Activities						
The MCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met ↑	Met	Met	
Annual Evaluation of the QI Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met	Met	Partially Met ↓	Met	**Weaknesses:** ▶ Molina's QI Program Evaluation did not include the analysis, results, and interventions for the availability of practitioners, the continuity and coordination of care, and the provider directory analysis. **Recommendations:** • When conducting an evaluation of the QI Program, ensure all QI activities are included in the evaluation.
The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors	Met	Met	Met	Met	Met	

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)

CCME's assessment of the health plans' utilization management (UM) programs included policies and procedures, medical necessity determination processes, pharmacy requirements, care management programs, websites, and reviews of approval, denial, appeal, and care management files.

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

Each health plan has a comprehensive UM program description along with numerous policies and procedures that guide staff in the implementation of UM activities for physical health, behavioral health, and pharmaceutical services for members. The Medical Director at each plan oversees all aspects of the UM Program.

Humana's UM Program Description contained incorrect information regarding the committee responsible for the oversight of UM functions and lacked information regarding the coverage for post stabilization care.

Each plan conducts reviews of service authorization requests using nationally recognized screening criteria, internal clinical review criteria, and other state established criteria. For behavioral health service authorization requests, ASAM criteria is used. Requests for medical services that do not meet medical necessity criteria or require further medical review are routed to a physician reviewer. Only licensed physicians can deny a medical service or treatment.

Policies and UM program descriptions discuss processes for applying criteria and disseminating criteria to members and providers as requested. Timeframes for completing service authorization requests are included in policies and/or the UM program descriptions. Humana had an issue with the timeframe for completing a non-expedited review. Humana's policy, Initial Case Review V 14.0 (Focus Health), incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy did not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.24*.

Each health plan assesses consistency in criteria application and decision-making through inter-rater reliability (IRR) testing for both physician reviewers and clinical reviewers for medical and behavioral health services. Inconsistencies were noted in Molina's IRR

methodology described in the UM Program Evaluation and the methodology in the IRR policy and procedures reviewed. Onsite discussion and additional documentation submitted revealed that a different process is used for IRR in South Carolina. Humana's UM Program Description and Policy, Utilization Management Inter-Rater Reliability, provided a summary of the IRR monitoring process. CCME found that Humana had not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.

The requirements for covering hysterectomies, sterilizations, and abortions are mentioned in the Member Handbooks, Provider Manuals, and on some health plan websites. During the Readiness Review (2021) for Humana, members and providers were not given the information regarding the specific requirements for covering hysterectomies, sterilizations, and abortions. Also, Humana did not have a policy or process for how hysterectomies, sterilizations, and abortions would be handled by the health plan. Humana addressed this deficiency and CCME found the corrections were made. The table that follows provides an overview of this deficiency and Humana's response.

Table 40: Humana's Previous EQR Medical Necessity Determination Deficiency and Response

Standard	EQR Comments
V B. Medical Necessity Determinations	
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	Hysterectomies, sterilizations, and abortions are mentioned in the Member Handbook and Provider Manual as covered benefits. However, the information is limited and does not include the specific requirements noted in the *SCDHHS MCO Policy and Procedure Guide, Section 4*. Also, Humana does not have a policy or process for how hysterectomies, sterilizations, and abortions will be handled by the health plan. *Quality Improvement Plan: Update the information in the Member Handbook and Provider Manual regarding the requirements noted in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4. Develop a process for how Humana will handle hysterectomies, sterilizations, and abortions that meets the state and federal requirements.*
Humana Response: Humana updated its Member Handbook and Provider Manual to provide additional detail regarding the requirements of Section 4 of the SCDHHS Policy and Procedure Guide regarding hysterectomies, sterilizations, and abortions. Additionally, Humana revised its Core Benefit Policy to address the process for handling hysterectomies, sterilizations, and abortions. Please refer to the following: • SC_TANF_EnrolleeHandbook_SCHL2L4EN at page 42 • Final HHH in SC Provider Manual at pages 9-10 • HM4200 – 07012021 – Program Description (Utilization Management)-006 at page 12 • SC TANF CHIP Specific Core Benefit Policy at pages 1, 7, 14	

All plans provide coverage for medications through their Pharmacy Benefit Managers. The Pharmacy and Therapeutics Committee for each plan is responsible for the development and updating of the pharmacy formulary or the preferred drug list (PDL). The *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3,* requires the health plans' Pharmacy & Therapeutics Committee to approve PDL changes prior to implementation. The contract also requires that negative PDL changes be published on the health plans' website at least 30 days prior to implementation. The changes posted by ATC, Healthy Blue, Humana, and Molina did not meet this requirement.

The health plans provided prompt notifications to members and providers of their utilization decisions. Humana provided several letter templates for notifying providers and members of adverse benefit determinations. The Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days when requested by the member or by the plan. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation to the member for when to use this contact information.

CCME reviewed a sample of approval and denial files received from each health plan. This review confirmed the health plans were using appropriate criteria and requests that did not meet criteria were sent to a physician to render a determination. The files reflected timely decisions and notifications. For the denials, the Adverse Benefit Determination letters were written in appropriate language for ease of member understanding, contained the rationale for the denial along with references to the criteria used, and supplied information on how to request an appeal.

Appeals

42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260

The health plans in SC are responsible for establishing a process for handling and responding to requests for an appeal of an adverse benefit determination. This process must meet the requirements outlined in the *SCDHHS Contract* and in federal regulations.

All the health plans have policies that address processes for handling appeals. The EQR of Molina's appeal process and policies found that standard appeal requests received verbally must be followed by a written request. CCME informed Molina that this was no longer a requirement by SCDHHS or federal regulations and should be removed.

During the Readiness Review of Humana there were several issues identified in Humana's policies and other documents regarding the definition of an appeal, the procedures for filing an appeal, and the timeliness guidelines for resolution. This year's review of the policies and other documents found those issues were corrected. The following table provides an overview of those issues and Humana's response.

Table 41: Previous EQR Appeals Deficiencies and Response for Humana

Standard	EQR Comments
V C. Appeals	
1. The MCO has in place policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including: 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	Definitions of the terms "appeal" and "adverse benefit determination," and a description of who may file an appeal, are documented in the South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E, Provider Manual, and Member Handbook. Additionally, the definition of an authorized representative and the requirement that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf are documented across all areas. The following issues with appeals definitions were noted: •The term "appeal" is not completely and clearly defined in the Key Words section and in the appeals section of the Member Handbook. It does not specify that an appeal is a request to review an adverse benefit determination as noted in the *SCDHHS Contract*. •The term "adverse benefit determination" is not defined or described in the Member Handbook. •Policy (South Carolina Medicaid Standard Appeal First Level)-001G refers to Kentucky Medicaid on the top of page three for definitions. *Quality Improvement Plan: Edit the Key Words section and appeals section in the Member Handbook to correctly define the term "appeal" according to 42 CFR §438.400 (b). Include a definition and description of the term "adverse benefit determination" in the Member Handbook as per the SCDHHS Contract, Section 9.1 (b). Remove the reference to Kentucky Medicaid from Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001G.*
Humana Response: Humana has updated the SC Medicaid Member Handbook to include definitions of "appeal" and "adverse benefit determination." Humana removed the reference to Kentucky Medicaid from the Standard Appeal First Level policy. (Humana reviewed the SC Medicaid Grievance and Appeal Policy but found no reference to Kentucky in that document.) Please refer to the following: • SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean at pages 10 & 56 • HM4200 – 07012021 – Policy(South Caroline Medicaid Standard Appeal First Level)-001G at page 3	
1.2 The procedure for filing an appeal;	Humana processes appeal requests for core benefits and services that are provided by the plan. Policy (South Carolina Medicaid Standard Appeal First Level)-001G states, "This process applies to medical and dental." The Member Handbook and Humana's staff confirmed the plan does not provide dental benefits to members and does not process appeals for dental services. Requirements for filing an appeal are documented in the South Carolina Medicaid Grievance and Appeal Policy DRAFT-001E, the Member Handbook, the Provider Manual, and in letters. The Appeal

Standard	EQR Comments
	Form and Appointment of Representative Form are available in the Member Handbook. The following documentation issues with appeal procedures were identified and discussed during the onsite: •Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B use the terms "notice of action" and "adverse determination notice" instead of the term "adverse benefit determination notice" or "notice of adverse benefit determination" according to *SCDHHS Contract, Section 9.1.5.* Also, the policies do not include the requirement that the plan will provide assistance with completing appeals forms or procedures, as required in *Contract Section 9.1.4.2* •Documentation of the requirements that Humana will provide an opportunity for members to present evidence related to their appeal, inform them of the limited time available to do that prior to the resolution (*SCDHHS Contract, Section 9.1.4.4.2.*) and inform members they can examine their appeal case file before and during the appeal process (*SCDHHS Contract, Section 9.1.4.4.3.*), is either incomplete or omitted from Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter. *Quality Improvement Plan:* *•Remove the dental reference from Policy (South Carolina Medicaid Standard Appeal First Level)-001G. Edit Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B to include the terms "adverse benefit determination notice" or "notice of adverse benefit determination" instead of the terms "notice of action" and "adverse determination notice" and include the requirement that Humana will provide assistance with appeals procedures.* *•Edit Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter to include the requirement that Humana will provide an opportunity for members to present evidence related to their appeal, inform them of the limited time available to do that prior to the resolution, and inform members they can examine their appeal case file before and during the appeal process according to requirements in SCDHHS Contract, Sections 9.1.4.4.2. and 9.1.4.4.3.*
Humana Response: Humana updated the referenced policies to address the Readiness Quality Improvement Plan Review comments for Line 25. Please refer to the following documents: • HM4200 – 07012021 – Policy(South Carolina Medicaid Standard Appeal First Level) – 001G • HM4200 – 07012021 – Policy(South Carolina Medicaid Expedited Appeal First Level) – 001B	

Standard	EQR Comments
• Final HHH in SC Provider Manual at page 32-33 • Appeal Acknowledgement Letter	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	Humana will resolve standard appeals and give notice within 30 calendar days of receipt and will resolve expedited appeals and provide notice within 72 hours of receipt, as noted in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E, Policy (South Carolina Medicaid Expedited Appeal First Level)-001B, and Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E. The following documentation issues with appeal timeframe guidelines were identified and discussed during the onsite: •Policy Medicaid Standard Appeal First Level)-001G does not include the requirement that notice of appeal resolution must be provided within 30 days of receipt of the appeal request. •Policy (Medicaid Expedited Appeal First Level)-001B, does not include the requirement members will be informed of their right to file a grievance if the member disagrees with the denial of expedited processing of an appeal. *Quality Improvement Plan: Edit Policy (Medicaid Standard Appeal First Level)-001G to include the requirement that standard appeal resolution notice must be provided within 30 days of receipt of the appeal request. Edit Policy Medicaid Expedited Appeal First Level)-001B, to include the requirement to inform the member of their right to file a grievance if the member disagrees with the denial of expedited processing of an appeal. Refer to requirements in SCDHHS Contract, Section 9.1.4.41 to 9.1.4.4.3.*
Humana Response: Humana updated the referenced policies to address the Readiness Quality Improvement Plan Review comments. Please refer to the following: HM4200 – 07012021 – Policy (South Carolina Medicaid Standard Appeal First Level) – 001G at page 7 HM4200 – 07012021 – Policy (South Carolina Medicaid Expedited Appeal First Level) – 001B at page 5	

The review of appeal files received from Select Health reflected timely acknowledgement, resolution, and notification of determinations. The determinations were made by professionals with appropriate clinical experience. Resolution letters were written clearly and provided instructions for requesting a State Fair Hearing.

ATC's appeal files reflected timely acknowledgments and resolutions. Policy SC.MM.13, Member Appeals, states "appeal decisions and requests to expedite an appeal decision will be made by a physician or other appropriate clinical peer of a same-or-similar specialty…" However, some of the appeal files reviewed did not meet this requirement. For three files, the physician who made the appeal decision was not of the same or similar specialty. Two of those cases were orthopedic cases reviewed by a physician who specializes in internal medicine, and the denials were overturned. One case was an

orthopedic case for a pediatric member. This case was reviewed by a physician who specializes in internal/geriatric medicine.

CCME's review of Healthy Blue's appeal files concluded that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in their policies. CCME identified the following issues with the appeal files:

- Three files required the member to submit the appeal request in writing after requesting the appeal verbally, even though this is no longer a requirement.
- The physician who made the appeal decision for three files was neither the same physician nor had a similar specialty as the requesting provider.

Also, Health Blue's policy indicates the member, or an authorized representative, is mailed a copy of the case file within 10 calendar days of receipt of the appeal. For nine files, the case file was not sent within the 10-day timeframe or was not sent at all. During the 2021 EQR, CCME noted that Healthy Blue was not consistently following Policy SC_GAXX_051, Member Appeal Process-SC, regarding the member's appeal case file. Healthy Blue addressed this deficiency as noted in *Table 42: Health Blue's Previous EQR Deficiencies and Quality Improvement Plan*. However, the file review determined this deficiency was not resolved.

Table 42: Healthy Blue's Previous EQR Deficiencies and Quality Improvement Plan

Standard	EQR Comments
Appeals	
The MCO applies the appeal policies and procedures as formulated.	Review of appeals files reflected Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. The following issues were noted: •Two versions of appeal case file letters were utilized; one version instructed members to respond with additional information within 10 calendar days from the date on the letter and the other version did not provide a timeframe to respond. During the onsite, Healthy Blue staff explained appeal case letters were updated in January 2021, to include instructions for members to respond with additional information within 10 calendar days from the date on the letter. This update was a recommendation from the 2020 EQR. •Appeal case files were not sent to members within 10 calendar days, as stated on page four of Policy SC_GAXX_051, Member Appeal Process, thus not allowing adequate time for the member to respond prior to the determination. •Inconsistencies with obtaining member consent when an appeal was requested from a provider.

Standard	EQR Comments
	Quality Improvement Plan: Follow processes in Policy SC_GAXX_051, Member Appeal Process to ensure appeal case file letters are mailed to members within 10 days of receiving the appeals request and to ensure member consent is obtained when an appeal is requested from a someone other than the member.
Healthy Blue Response: The following process updates have been taken to ensure the appeal policy is followed: •The updated Case File letter (stating member has 10 days to give additional information) is loaded into the electronic appeals system (PEGA) as of 1/2021. The previous case file letter has been retired from the system. •To ensure case files are sent timely, the responsibility of generating case files has been given to the triage team. The triage team checks the work basket for all new appeals to verify the appeal is entered correctly and acknowledgement letter has been sent. As part of this process, the triage team will ensure case files are created and sent to members within 10 calendar days from the receipt date of the appeal, as stated in Policy SC_GAXX_051, Member Appeal Process. •To ensure member consent is obtained, the triage team will make outbound calls to both the provider and member for consent. If consent is not obtained by the triage team, the nurse assigned to the case will make a second set of outbound calls to provider and member for consent. If consent is not obtained after reasonable effort, the appeal will be dismissed.	

Humana provided one appeal file. The file reflected the acknowledgement and resolution were completed timely. An appropriate physician reviewed the file and made the decision to uphold the original denial. The resolution notice contained the following errors:

- The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition.
- The letter stated, "a specialist in the Grievance and Appeal Department hereby denies your plan appeal."
- The language used to describe why the denial was upheld appeared to be above the 6th-grade reading level.

A sample of Molina's appeal files found three files that were untimely and four files where the physician who made the appeal decision was not of the same or similar specialty as the ordering physician. Two of those cases were pediatric cases reviewed by a physician who specializes in internal medicine and two plastic surgery cases also reviewed by a physician who specializes in internal medicine. According to staff, the physicians reviewing appeal requests are directed to use criteria and matching specialty was not necessary. Molina was cautioned regarding allowing physician reviewers to only utilize criteria when making medical necessity decisions on appeals.

Case Management

42 CFR § 208, 42 CFR § 457.1230 (c)

The health plans' Care Management (CM) programs incorporate care management, care coordination, transition management, and prevention activities to ensure appropriate care for members of various risk levels, assist members in meeting needs, and improving outcomes when possible. Each of the plans has program descriptions that include information about the program's purpose, scope, member identification, screenings, stratification, and assessments. Policies and procedures provide additional detail about Care Management (CM) processes and requirements. Minor issues were noted in the program descriptions, policies, and procedures:

- For ATC, information about Targeted Case Management Services was not found in any of the Care Management policies.
- Humana's Care Management Program Description did not describe the structure of the program.
- Molina's Integrated Care Management Program and Complex Case Management procedure did not clearly define when and for whom a comprehensive assessment is conducted or the frequency of routine outreach for various risk levels.

The MCOs routinely assess member satisfaction with the CM programs through survey processes and assessments of member and provider complaints and grievances about the CM Programs. In addition, overall annual program evaluations are conducted. Results of these member satisfaction and overall program evaluations are used to identify barriers and opportunities for improvement. Results are reported to appropriate health plan committees.

A sample of CM files was reviewed during each health plan's EQR. Overall, files reflected care management and coordination activities are conducted as required. For one ATC file, the member verbalized concerns with food availability and with money for food, but assessment notes indicated no economic or social conditions had been identified and the care plan did not address the member's concern.

Tables 43 and 44 display issues identified during the previous EQRs for Humana and Select Health and the plans' responses to those findings. The most recent EQRs confirmed these issues were corrected.

Table 43: Humana's Previous EQR Care Management and Coordination Deficiencies and QIP

Standard	EQR Comments
V. D Care Management and Coordination	

Standard	EQR Comments
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	Comprehensive assessments are conducted by Humana Care Managers and cover various life topics such as health risks, cultural and linguistic needs, and behavioral health status. The comprehensive assessment and care plan will be completed within 30 days for all enrollees including those stratified to High and Complex risk. CCME could not identify Humana's process for ensuring Targeted Care Management (TCM) services are provided. During the virtual onsite Humana staff explained that their approach to TCM services is described in the Care Management Program Description under the "Coordinating CM With External Partners" and the "Enrollees with Special Health Care Needs (SHCN)" sections. However, the sections identified do not define nor describe TCM, or identify the population to receive TCM services according to requirements in the *SCDHHS Contract, Section 4.2.27.* *Quality Improvement: Define and describe, in a program description or other document, Humana's process for ensuring TCM services are provided to the identified population according to requirements in SCDHHS Contract Section 4.2.27.*
Humana Response: Humana has updated its Care Management Program Description to reflect Humana's process for ensuring TCM services are provided to the identified population per SCDHHS Contract Section 4.2.27. Please refer to the following document: HM4200 - 07012021 - Program Description (Care Management)-004 at page 13.	

Table 44: Select Health's Previous EQR Care Management Deficiency and QIP

Standard	EQR Comments
V. D Care Management and Coordination	
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	Select Health applies the Complex Care Management Standards of Practice to the care management program. CCME was not able to identify how the plan provides coordinated health care for members that require Targeted Case Management (TCM) Services, such as children in the juvenile justice system, members with sickle cell disease, and members who are sensory impaired. During the onsite teleconference, staff confirmed the requirements for TCM services were unexpectedly not documented in a policy. *Quality Improvement Plan: Include the requirements for TCM services in a policy or other documents, as noted in SCDHH Contract Section 4.2.27*

Standard	EQR Comments
Select Health: The Population Health Policy Care Management Standard of Practice PH – CC 201S was revised to include the requirements for TCM services on December 10, 2020. Please see the bottom of page 5 and top of page 6 of the updated policy. A copy of the updated policy is included.	

Over/Under Utilization

The health plans are required to monitor and analyze utilization data to identify trends or issues that may provide opportunities for quality improvement. Four of the five health plans submitted information on quarterly or annual trending of utilization data across medical and behavioral health services. Policies for over- and under-utilization were included within the utilization management departments, though evaluations and actions to improve utilization measures were stated to be a multi-department effort for all plans.

Four health plans analyzed and monitored utilization data for several services and offered recommendations based on findings to their respective committees. Humana is currently developing utilization monitoring policies and procedures. Humana's desk materials did not contain specific policies or action steps planned for addressing over and under-utilization. This was an issue identified during the Readiness Review of Humana that was not corrected. *Table 45: Humana's Previous EQR Over/Underutilization Deficiency and Response* notes the EQR finding and Humana's response.

Table 45: Humana's Previous EQR Over/Underutilization Deficiency and Response

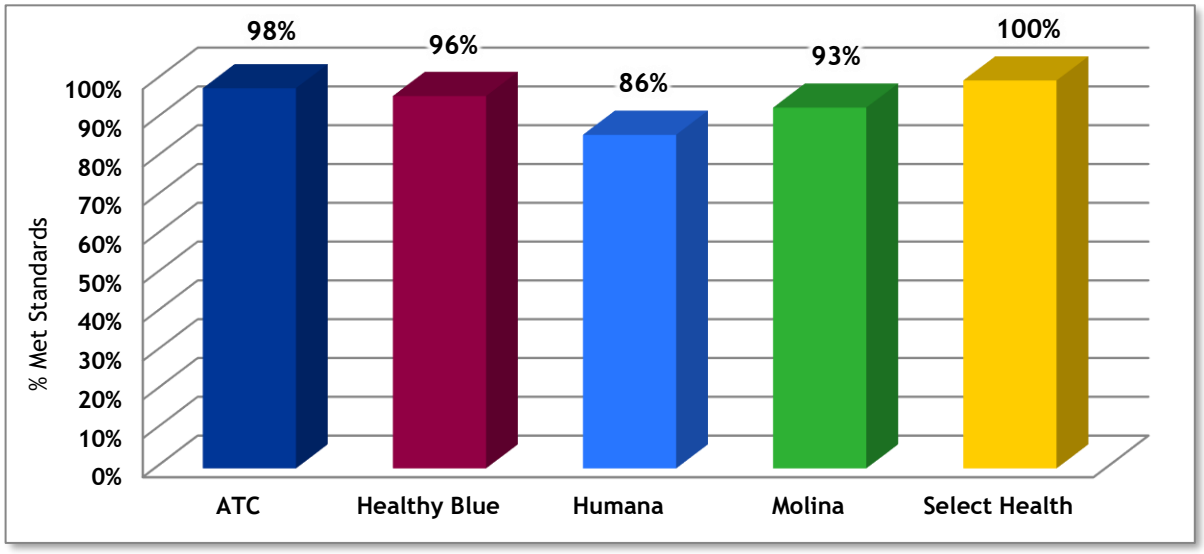
Standard	EQR Comments
V E. Evaluation of Over/Underutilization	
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	A Fraud, Research, Analytics and Concepts (FRAC) document, UM Data Plan, and UM Program Description were submitted to review Humana's approach for evaluating over and under-utilization. However, these documents did not include a defined timeline for utilization data analysis, specific areas of interest (readmission, ER rates, pharmacy, etc.), who will set target rates, who will assist with monitoring and interventions, and plans to mitigate when issues are identified. *Quality Improvement Plan: Develop a plan or process for how Humana will monitor over and under-utilization.*
Humana Response: Humana has updated its UM Data Plan to reflect the process for monitoring over and underutilization.	

In response to this finding, Humana's UM Data Plan stated that the Medical Management Committee creates plans to mitigate when issues are identified, but how that is conducted was not clearly documented. Humana indicated that the utilization

management team was still building this process. The upcoming EQR will offer a better assessment of the over- and under-utilization mechanisms and monitoring at Humana.

A comparison of all scores for the UM section is illustrated in *Figure 10: Utilization Management*.

Figure 10: Utilization Management



A comparison of the plans' scores for the standards in the Utilization Management section is illustrated in *Table 46: Utilization Management Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 46: Utilization Management Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Utilization Management (UM) Program						
The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Met	Met	Met	Met	Met	**Strengths:** ▶ The UM Program Descriptions are well-written and appropriately describe the goals, scope, and structure of each UM Program. ▶ Each health plan has a medical director that provides oversight for the UM program. **Weaknesses:** ▶ Humana's policy incorrectly listed the timeframe for completing a non-expedited review and did not include the 14-day extension requirements or the timeframe for completing a request for Substance Abuse treatments. **Recommendations:** • Humana should correct the errors noted in their policy related to timeliness for UM decisions.
Structure of the program and methodology used to evaluate the medical necessity	Met	Met	Met	Met	Met	
Lines of responsibility and accountability	Met	Met	Met	Met	Met	
Guidelines / standards to be used in making utilization management decisions	Met	Met	Met	Met	Met	
Timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Met	Partially Met ↓	Met	Met	
Consideration of new technology	Met	Met	Met	Met	Met	
The absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met	
The mechanism to provide for a preferred provider program	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met	
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met	
Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met	**Strengths:** ▶ Each health plans use nationally recognized screening criteria for their services authorization requests. ▶ UM files reflected use of appropriate criteria and appropriate attempts to obtain additional information when needed. ▶ Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-Rater Reliability testing. All plans except Humana shared the results of their testing scores. **Weaknesses:** ▶ Humana had not conducted IRR testing despite a policy indicating that associates with at least
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met	
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Met	Met ↑	Met	Met	
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met	
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Partially Met ↓	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health
Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Partially Met ↓	Partially Met ↓	Partially Met ↓	Partially Met ↓	Met
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Met	Met	Met	Met
Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Met
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met
A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis	Met	Met	Partially Met ↓	Met	Met

▶ = *Quality*
▶ = *Timeliness*
▶ = *Access to Care*

three months tenure are expected to complete IRR testing.

- ▶ The negative PDL changes were not published on the health plans' website at least 30 days prior to implementation as required by the *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3*. The changes posted by ATC, Healthy Blue, Humana, and Molina did not appear to meet this requirement.
- ▶ Humana's Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation for when to use this contact information.

Recommendations:

- Ensure Utilization management standards/criteria are consistently applied to all members across all reviewers.
- Members and providers should be notified of negative PDL changes by posting the change on the health plans' website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3*.

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
for the denial of service and the procedure for appeal						• Humana should correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.
Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including	Met	Met	Met	Met	Met	**Strengths:** ▶ The Plans provide assistance with appeals and services upon request, including providing interpreter services and materials translated in other languages. ▶ Timeliness guidelines for processing appeals met the contract and federal requirements for all health plans. **Weaknesses:** ▶ Molina requires the member to follow-up an appeal received verbally with a written request even though this requirement was removed from the SCDHHS Contract and the Federal Regulation. ▶ Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. ▶ Humana provided one appeal file. The resolution notice did not indicate the decision to uphold the original denial was made by a physician and the language used to describe why the denial was
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Met	Met ↑	Met	Met	
The procedure for filing an appeal	Met	Met	Met ↑	Partially Met ↓	Met	
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met	
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met	
Timeliness guidelines for resolution of the appeal as specified in the contract;	Met	Met	Met ↑	Met	Met	
Written notice of the appeal resolution as required by the contract	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Other requirements as specified in the contract	Met	Met	Met	Met	Met	upheld appeared to be above the 6th grade reading level. ▶ Molina had three appeal files that were untimely and four files where the physician who made the appeal determination was not of the same or similar specialty as the ordering physician. **Recommendations:** • Revise all documents related to the process for filing an appeal and remove the requirement that indicates a standard request for an appeal received verbally must be followed by a written request. • Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy, *SCDHHS Contract*, and federal regulations. Implement interventions to address the barriers. • Develop a process for monitoring resolution notices to ensure the letter contains correct reviewer information and the language meets the SCDHHS 6th reading level. • For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. Re-educate physician reviewers regarding only utilizing review criteria and not considering individual medical conditions when making appeal determinations.
The MCO applies the appeal policies and procedures as formulated	Met	Partially Met	Partially Met	Partially Met ↓	Met	
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met	
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Case Management *42 CFR § 208, 42 CFR § 457.1230 (c)*						
The MCO formulates policies and procedures that describe its case management/care coordination programs	Met	Met	Met	Met	Met	**Strengths:** ▶ Program Descriptions, along with policies and procedures, provide detailed information about each health plan's Case Management, Population Health Management, and/or Care Transitions programs. ▶ The MCOs use information and data from various sources to identify members who may benefit from Care Management services. ▶ Member risk levels are identified and described, and appropriate activities are incorporated into the risk levels. ▶ The health plans have implemented processes to evaluate and assess member satisfaction with Care Management programs. **Weaknesses:** ▶ Minor issues were noted in documentation in program descriptions, policies, and procedures related to Targeted Case Management Services (ATC), program structure, (Humana), and requirements for assessment and outreach (Molina). ▶ Overall, CM files reflected appropriate activities are conducted and established processes are followed. One ATC file, however, revealed a
The MCO has processes to identify members who may benefit from case management	Met	Met	Met ↑	Met	Met	
The MCO provides care management activities based on the member's risk stratification	Met	Met	Met	Met	Met	
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met	Met ↑	
The MCO has developed and implemented policies and procedures that address transition of care	Met	Met	Met	Met	Met	
The MCO has a designated Transition Coordinator who meets contract requirements	Met	Met	Met	Met	Met	
The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary	Met	Met	Met	Met	Met	
Care management and coordination activities are conducted as required	Met	Met	Met	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						member concern was not addressed in care planning activities. **Recommendations:** • Ensure Care Management program descriptions, policies, and/or procedures thoroughly document program processes and requirements. • Ensure all member concerns are addressed in care plans.
Evaluation of Over/Underutilization						
The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	Met	Met	Partially Met	Met	Met	**Strengths:** ▶ The analysis of over and under-utilization data was comprehensive and demonstrated a focus on monitoring, evaluating, and addressing utilization issues for four of the health plans. ▶ Plans collecting utilization data showed evidence of monitoring and analysis of data for trending and impacts on appropriate use of services and resources. **Weaknesses:** ▶ Humana did not have a specific policy or action steps planned for addressing the process for how the monitoring of over and underutilization will be conducted. This was an issue identified during the Readiness Review.
The MCO monitors and analyzes utilization data for under and over utilization	Met	Met	Not Evaluated	Met	Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						▶ ER visits and readmissions remain an area of opportunity for utilization monitoring and intervention. **Recommendations:** • Provide more detail in the Utilization Management Data Plan regarding issues identified during the monitoring of over or under-utilization. The data plan should include steps If monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues. • Establish work groups to identify opportunities for improving ER visit and readmission rates.

F. Delegation

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

Health plan policies provide detailed information about processes for delegation of activities to external entities. The policies address pre-delegation assessment, routine monitoring, annual oversight, delegation agreements, etc. At the completion of the pre-delegation assessment, if delegation is approved, a written delegation agreement that serves as the delegation contract is implemented. The agreement specifies the terms and conditions, processes for ongoing monitoring, requirements for sub-delegation, reporting requirements, performance expectations, and actions that may be taken as a result of unsatisfactory performance.

Each of the MCOs provided documentation of ongoing monitoring and annual oversight of their delegates. For ATC, the documentation revealed that although annual oversight was initiated as early as May 2021, the anticipated completion date was Q1, 2022. For Healthy Blue, file review worksheets/tools used for auditing credentialing delegates did not show that all credentialing requirements were monitored. For Humana, a recommendation was offered for a minor change of the Credentialing Annual Audit Tool to clarify the documentation. No issues with annual oversight and ongoing monitoring were noted for Molina and Select Health.

Deficiencies identified during the previous EQRs for Healthy Blue, Humana, and Select Health are noted in Tables 47 through 49. Each of the plans corrected the previously identified issues; however, for Healthy Blue, a new issue was noted with the audit tools during the most recent EQR.

Table 47: Healthy Blue's Previous EQR Delegation Deficiency and QIP Response

Standard	EQR Comments
V I. DELEGATION	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Documentation of delegation oversight was submitted for review. The following issues were identified: •For two delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing. This is a repeat finding from the previous EQR. •For one delegate, the MCO Credentialing File Review Workbook does not indicate whether the delegate was monitored for querying the Social Security Death Master File, as stated in Policy MCD-10, Medicaid Delegated Credentialing. •For five credentialing delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for collection of nurse practitioner collaborative agreements.

Standard	EQR Comments
	Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National Plan and Provider Enumeration System and Social Security Death Master File, as well as collection of collaborative agreements between nurse practitioners and supervising physicians. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.
Healthy Blue's response: Credentialing and Recredentialing delegates are monitored for conducting required queries. We have pre-populated the notes section of the MCO Credentialing File Review Workbook (Audit tool) used to assess credentialing delegates with the National Plan and Provider Enumeration System review, the Social Security Death Master File review, and the Collection of Nurse Practitioner Collaborative Agreements review. We have also made it mandatory for our staff auditors to use the pre-populated template when conducting future audits.	

Table 48: Humana's Previous EQR Delegation Deficiency and QIP Response

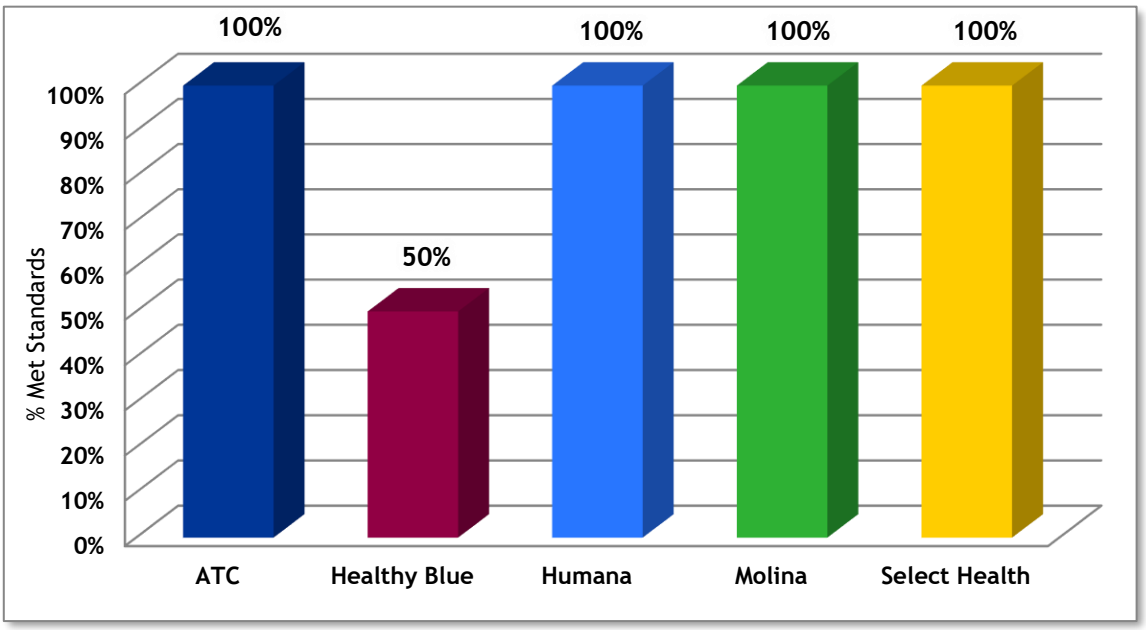
Standard	EQR Comments
V I. DELEGATION	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Policy (Delegation)-001 states, "The Delegation Compliance department will perform a pre-delegation audit prior to any function being delegated to a prospective entity upon receipt of the Request for Delegation form and the Pre-delegation Questionnaire (claims delegation only). The pre-delegation audit will include evaluation of a prospective delegate's compliance and performance capacity against state, federal, accreditation and Humana standards…" The policy lists items that will be evaluated during the pre-delegation audit. Issues identified in the Delegation Policy attached to Policy (Delegation)-001 include: •Requirements for sub-delegation under multiple headings in the policy do not address the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor. •The policy addresses checking the OIG and SAM during the pre-delegation assessment but does not address the queries on an ongoing basis. Refer to the *SCDHHS Contract, Section 2.5.13.* *Quality Improvement Plan: Revise the Delegation Policy attached to Policy (Delegation)-001 to include the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor and to include requirements for checking the OIG and SAM on an ongoing basis.*
Humana Response: Please see Humana's revised HM4200 - 12012001 - Policy (Delegation)-001 at pages 7 & 9.	

Table 49: Select Health's Previous EQR Delegation Deficiency and QIP Response

Standard	EQR Comments
VI. DELEGATION	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Policy 277.010, Vendor and Delegate Management Oversight of Delegated Entities, includes the process for annual oversight monitoring of all delegates. A score of at least 95% is required to pass the annual assessment. Policy CP 210.107, Delegation of Credentialing and Recredentialing Activities, includes the process for the annual monitoring of the credentialing delegates. Select Health requires all credentialing delegates to score 100% in all areas that have been delegated. For delegates not meeting the goal, a corrective action plan is required. The results of the annual monitoring of all delegates were provided. For delegates not meeting the monitoring goals, corrective action(s) were implemented. Select Health provided a copy of the Credentialing/Recredentialing file review tool and the monitoring results for the delegates conducting the credentialing and recredentialing activities. The tools did not include the verification of the Clinical Laboratory Improvement Amendment (CLIA) Certificate and the requirements for the nurse practitioners as required in Exhibit B of Policy CP 210.107. *Quality Improvement Plan: Ensure delegate oversight documentation for the file review of delegates conducting credentialing and recredentialing activities includes CLIA Certificates and the requirements for Nurse Practitioners.*
Select Health's Response: The SC State, Federal, Medicare File Review tool has been updated to include file review of CLIA and NP/PA protocols moving forward for 2021 audits. These updates can be found from columns CA-CK. A copy of the revised tool is included.	

Figure 11: Delegation displays the percentage of "Met" scores for each MCO's review of Delegation.

Figure 11: Delegation



A comparison of the plans' scores for the standards in the Delegation section is illustrated in *Table 50: Delegation Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 50: Delegation Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Delegation *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Met	Met	**Strengths:** ▶ Each of the health plans execute written agreements with entities to which health plan functions are delegated. ▶ The written agreements outline the functions to be delegated, performance expectations, reporting responsibilities, etc. ▶ The MCOs conduct annual auditing and routine monitoring of delegate performance. **Weaknesses:** ▶ Issues regarding annual oversight of delegated entities included untimely completion of annual oversight (ATC) and failure to monitor delegates for all required credentialing elements (Healthy Blue). **Recommendations:** • Ensure annual oversight activities are completed in a timely manner and that credentialing/recredentialing delegates are monitored for all required credentialing and recredentialing elements.
The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Met	Partially Met	Met ↑	Met	Met ↑	

G. State Mandated Services

42 CFR Part 441, Subpart B

Each of the health plans has an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program that follows the American Academy of Pediatrics periodicity schedule. Four of the MCOs (ATC, Healthy Blue, Molina, and Select Health) have established processes to monitor provider compliance with administering recommended immunizations and providing recommended EPSDT services through medical record reviews, claims and encounter data monitoring, etc. For Humana, no policy and/or procedure was identified describing processes for monitoring provider compliance specific to administering immunizations and performing EPSDT or well-care services for members, and Humana provided no evidence of tracking provider compliance with immunizations and EPSDT services.

All of the MCOs ensure core benefits and services are provided to members as required by the *SCDHHS Contract* and Federal Regulations.

Every plan is required to address deficiencies identified in the previous EQR. For the most recent EQRs, four of the five health plans were found to have uncorrected deficiencies from the previous EQR.

- For ATC, the uncorrected deficiency was related to failure to include all required Status 1 Providers in Geo Access mapping.
- For Healthy Blue, the uncorrected deficiency was related to failure to follow health plan policy for sending appeal case files within a specified timeframe.
- For Humana, the uncorrected deficiency was related to failure to include nurse practitioner collaborative agreements in credentialing and recredentialing files; dating credentialing/recredentialing approval letters prior to the approval determination; and no policy or action steps planned for addressing the monitoring of over- and under-utilization.
- For Select, the uncorrected deficiency was related to discrepancies in the timeframe for PCP appointment access and lack of improvement in the Telephonic Provider Access Study conducted by CCME were identified again during the current EQR.

Tables 51 through 53 display the identified findings from the previous EQRs and the health plans' responses to the deficiencies.

Table 51: ATC's Previous EQR State Mandated Services Deficiency and Response

Standard	EQR Comments
VII. State Mandated Services	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	Geo Access mapping conducted on December 21, 2020 did not include the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. This was an issue identified in the previous EQR. *Quality Improvement Plan: Develop and implement a monitoring process to ensure specifications for Geo Access mapping, including all Status 1 providers as defined in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*
ATC Response: ATC will ensure when developing the Annual Network Assessment Report to run Geo Access mapping for all Status 1 providers as required and defined in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*	

Table 52: Healthy Blue's Previous EQR State Mandated Services Deficiency and Response

Standard	EQR Comments
VII. State Mandated Services	
The MCO addresses deficiencies identified in previous independent external quality reviews.	During the previous EQR, documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Practitioner Databank and the National Plan and Provider Enumeration System. The current EQR found that documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System. *Quality Improvement Plan: Implement quality improvement plans from the External Quality Review to address all identified deficiencies.*
Healthy Blue's Response: Healthy Blue will fully implement all Quality Improvement Plans described above, as well as address recommendations, identified in the audit report.	

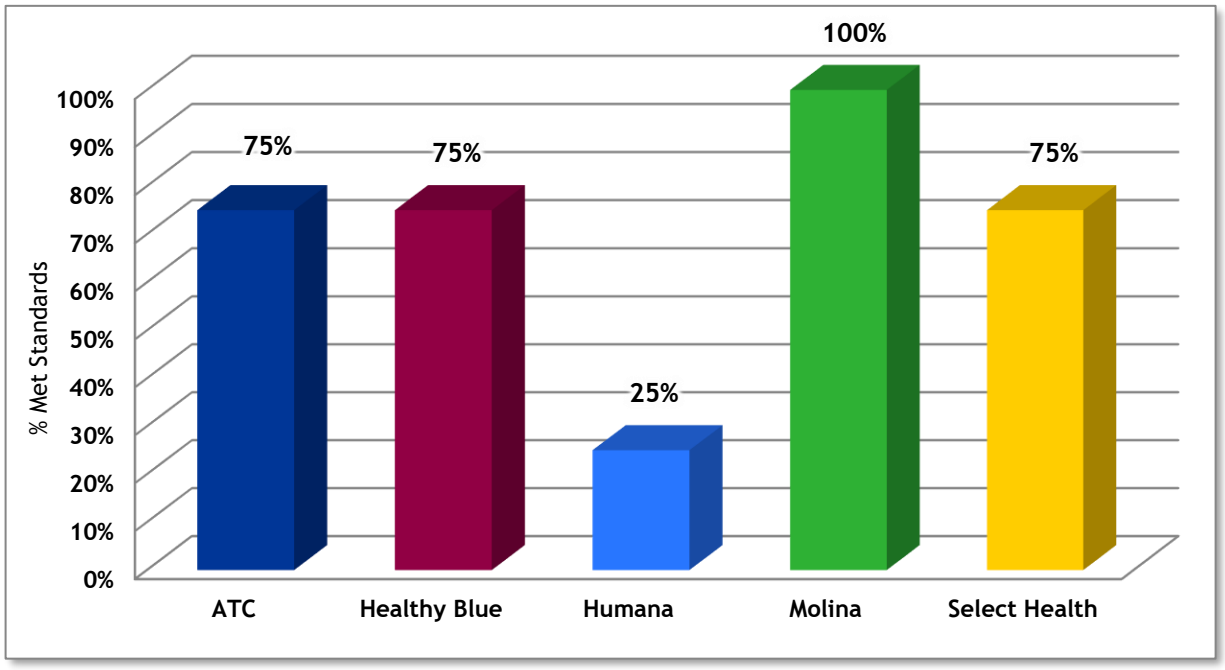
Table 53: Select Health's Previous EQR Deficiency and Response

Standard	EQR Comments
VII. STATE MANDATED	

Standard	EQR Comments
3. The MCO addresses deficiencies identified in previous independent external quality reviews	A deficiency noted in the previous EQR related to documentation of network adequacy standards in annual reporting documents was noted again in the current EQR. *Quality Improvement Plan: Ensure all deficiencies identified during the EQR process are addressed with actions to correct the deficiency and prevent recurrence.*
Select Health: The health plan will incorporate all items identified in the EQR QIP report in its ongoing monitoring and auditing plans for the coming year. A focused review of these items will be performed as well during the course of the year with each department leader to ensure ongoing compliance and visibility. Additionally, the health plan is creating a written policy regarding its monitoring and auditing activities to ensure there is a formal documented process for addressing EQR identified deficiencies as part of its monitoring and auditing plans.	

Each plan's percentage of "Met" scores is demonstrated in *Figure 12: State-Mandated Services*.

Figure 12: State-Mandated Services



A comparison of the plans' scores for the standards in the State Mandated Services section is illustrated in *Table 54: State Mandated Services Comparative Data*. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 54: State-Mandated Services Comparative Data

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
State Mandated Services *42 CFR Part 441, Subpart B*						
The MCO tracks provider compliance with administering required immunizations	Met	Met	Not Met	Met	Met	**Strengths:** ▶ Four of the five MCOs have appropriate processes to monitor and track provider compliance with provision of required immunizations and for conducting required EPSDT services. ▶ All of the MCOs provide required core benefits to members. **Weaknesses:** ▶ Humana did not have a policy or procedure for monitoring provider compliance with administering immunizations and performing EPSDT or well-care services for members and provided no evidence that it is currently monitoring or tracking this information. ▶ Four out of the five MCOs were noted to have uncorrected deficiencies from the previous year's reviews. **Recommendations:** • Humana should develop and implement a policy/procedure for monitoring provider compliance with immunization administration and EPSDT/well-care services. Results of the monitoring should be reported to appropriate
Performing EPSDTs/Well Care	Met	Met	Not Met	Met	Met	
Core benefits provided by the MCO include all those specified by the contract	Met	Met	Met	Met	Met	
The MCO addresses deficiencies identified in previous independent external quality reviews	Not Met	Not Met	Not Met	Met	Not Met	

Standard	ATC	Healthy Blue	Humana	Molina	Select Health	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
						committees and used for quality improvement activities. • Ensure that Quality Improvement Plans from EQRs are addressed and that action is implemented to correct all identified deficiencies.

H. South Carolina Solutions

SCDHHS contracts with South Carolina Solutions (Solutions) to provide Primary Care Case Management (PCCM) and care coordination for the Medically Complex Children's Waiver (MCCW) Program. CCME's review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs. To access Solutions' compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into four areas. The following is a summary of the review results for those areas. The tables reflect the scores for each standard evaluated in the EQR. The arrows indicate a change in the score from the previous review. For example, an arrow pointing up (↑) would indicate the score for that standard improved from the previous review and a down arrow (↓) indicates the standard was scored lower than the previous review. Scores without arrows indicate there was no change in the score from the previous review.

Administration

Solutions maintains written policies and procedures for all areas of the company. Policies include the effective date, review dates, the date of the most recent revision, and identification of approval activity. The Compliance Department maintains a master list of all policies and facilitates the annual review process. Each Business Unit's leadership is responsible for disseminating policies to staff and overseeing policy implementation. The processes for how polices are managed are included in policy CHS.ADM.ALL.01.01, Policy and Procedure Management. Staff have access to the policies on two shared drives and on Healthicity.

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

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

Solutions' policy CHS.CRED.MCCW.03.06, Clinical Staff Credentialing, provides the process for verification of staff qualifications and screenings. The policy discusses the verification of clinical licenses, CPR certification, TB Test results, and background

checks. Policy HR 01.41, Background Check Policy and Procedure (Non-Clinical Positions), addresses the criminal background checks for non-clinical staff.

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

Other findings in the personnel files included a lack of purified protein derivative (PPD) skin testing results for clinical staff, and no evidence of HIPAA and Compliance training. Solutions indicated that because clinical staff were not conducting face-to-face visits due to COVID-19, the PPDs were not required. The roster of employees completing the required HIPAA and Compliance training was provided after the onsite.

All staff receive HIPAA and information security training prior to being allowed access to Protected Health Information. On a continuing education basis, all employees receive training at least annually.

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

Information Systems Capabilities

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

A comparison of the plans' scores for the standards in the Administration section is illustrated in the table that follows. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 55: Administration Comparative Data

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
General Approach to Policies and Procedures		
Policies and procedures are organized, reviewed, and available to staff	Met	**Strength:** ▶ Solutions' policies and procedures were found to be reviewed in a timely manner.
Organizational Chart / Staffing		
The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities: Administrative oversight of day-to-day activities of the organization	Met	**Weaknesses:** ▶ It was concerning that the Chief Medical Officer was also serving as the Executive Director and the Interim Medical Director. ▶ Personnel files lacked evidence of the monthly exclusion screenings as required by Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks. **Recommendations:** ▶ Continue the recruiting efforts to fill the Medical Director position. Also, determine if the vacant Executive Director position will be filled. ▶ Review processes needed to ensure that steps are taken to complete monthly exclusion monitoring to align with Policy CHS.COMP.ALL.02.01, OIG and Other Exclusion List Checks Monitoring, Oversight, and Reporting.
Pre-assessment	Met	
Care coordination and enhanced case management	Met	
Provider services and education	Met	
Quality assurance	Met	
Designated compliance officer	Met	
The organization formulates and acts within policies and procedures which meet contractual requirements for verification of qualifications and screening of employees. At a minimum, the following are included: Criminal background checks are conducted on all potential employees	Met	
Verification of nursing licensure and license status	Met	
Screening all employees and subcontractors monthly to determine if they have been excluded from participation in state or federal programs	Met	
Ensuring Care Coordinators and Pre-Admission Screening staff meet all contract requirements	Met	
Ensuring staff are independent of the service delivery system and are not a provider of other services which could be incorporated into a participant's Person-Centered Service Plan	Met	
Employee personnel files demonstrate compliance with contract and policy requirements	Partially Met ↓	
Governing Board/Advisory Board		

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Organization has established a governing body or Advisory Board	Met	
The responsibility, authority, and relationships between the governing body, the organization, and network providers are defined	Met	
Contract Requirements		
The organization carries out all activities and responsibilities required by the contract, including but not limited to: Available by phone during normal business hours 8:30 am to 5:00 pm Monday through Friday	Met	
Adherence to contract requirements for holidays and closed days	Met	
Processes to conduct onsite supervisory visits within 5 days of receiving a request from SCDHHS	Met	
Organization and participant record retention and availability as required by the contract	Met	
Participant materials written in a clear and understandable manner, and are available in alternate formats and translations for prevalent non-English languages	Met	
Processes are in place to ensure care coordination services are available statewide	Met	
Confidentiality		
The organization formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health and information privacy	Met	
Data Systems/Security		
Policies, procedures and/or processes are in place for addressing data, system, and information security and access management	Met	**Strength:** ▶ SC Solutions backup testing frequency (weekly) surpasses the test frequency typically practiced in the industry.
The organization has a disaster recovery and/or business continuity plan that has been tested and the testing documented	Met	
Compliance and Program Integrity		

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The organization has policies/procedures in place designed to guard against fraud, waste, and abuse, and including the following: Written policies, procedures, and standards of conduct comply with federal and state standards and regulations	Met	
A compliance committee that is accountable to senior management	Met	
Employee education and training that includes education on the False Claims Act, if applicable	Met	
Effective lines of communication between the compliance officer and the organization employees, subcontractors, and providers	Met	
Enforcement of standards through well-publicized disciplinary guidelines	Met	
Provisions for internal monitoring and auditing	Met	
Provisions for prompt response to detected offenses and development of corrective action initiatives	Met	
A system for training and education for the Compliance Officer, senior management, and employees	Met	
Processes for immediate reporting of any suspicion or knowledge of fraud and abuse	Met	
The organization reports immediately any suspicion or knowledge of fraud or abuse	Met	

Provider Services

Although Solutions' provider network was closed at the time of the review, the organization indicated it would be reopening the network to new providers soon. When new providers are accepted into the network, Solutions conducts an orientation session that covers a broad range of topics to acclimate providers to the MCCW program so that they may care for MCCW participants.

The Provider Manual is posted on Solutions' website and is the main resource for network providers. The manual includes key contact information, goals of the MCCW, program processes and requirements, and information about the role of the provider in caring for MCCW participants. The Provider Manual also addresses requirements for medical record documentation, retention, and storage. Free language services are available, and the

Provider Manual includes both toll-free telephone and teletypewriter (TTY) numbers to access language services, which include qualified verbal and sign language interpreters. Member materials are available in alternate formats, such as large print, braille, audio, etc.

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

A comparison of the plans' scores for the standards in the Provider Services section is illustrated in the table that follows. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 56: Provider Services Comparative Data

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Met	**Weakness:** ▶ Ongoing provider education was not being conducted. **Recommendation:** • Consider conducting ongoing provider education using alternate forums such as webinars, virtual meetings, etc.
Initial provider education includes: Organization structure, operations, and goals	Met	
Medical record documentation requirements, handling, availability, retention, and confidentiality	Met	
How to access language interpretation services	Met	
The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Met	

Quality Improvement

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

appendices. During the onsite, staff explained the Strategic Quality Plan did not have appendices and had been sent to the CQMC via email for review and approval.

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

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

Solutions' Corporate Board of Directors is ultimately responsible for the health plan's Quality Improvement Program. The Board is responsible for the initiation of the QI Program and directs its implementation throughout the organization. The Compliance & Quality Management Committee is the local committee responsible for oversight of all aspects of the QI Program. The committee is chaired by the Chief Medical Officer. Voting members include the Chief Compliance officer, Manager of Medical Informatics, the Quality Coordinator, and other Team Leads.

According to the Strategic Quality Plan, the CQMC meets no less than quarterly. The minutes received indicated for 2021, the committee met in the 1st and 3rd quarters. Solutions confirmed the meetings scheduled for the 2nd and 3rd quarters had to be canceled. For 2022, the committee is on track for meeting quarterly. The minutes of the meetings held in the 1st and 2nd quarter of 2022 were provided.

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

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

A comparison of the plans' scores for the standards in the Quality Improvement section is illustrated in the table that follows. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 57: Quality Improvement Comparative Data

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The Quality Improvement (QI) Program		
The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants	Met	**Strength:** ▶ The Quality Work plans for 2021 and 2022 were complete. **Weaknesses:** ▶ The 2022 Strategic Quality Plan contained references to appendices that were not included in the document. ▶ Committee approval for the 2022 Strategic Quality Plan and the Quality and Performance Improvement 2021 Annual Report was not documented in the committee minutes. ▶ The project documents lacked details regarding the selected study question and aim for the projects. Clearly defined measurable indicators, the baseline measurement, specific goal(s), the method for data collection, identified barriers and interventions to address those barriers was also not included. **Recommendations:** • Correct the Strategic Quality Plan and remove the references to appendices.
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Met	

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
		• Update the CQMC minutes and add an addendum regarding the electronic review and approval of the 2022 Strategic Quality Plan and the Quality and Performance Improvement 2021 Annual Report that occurred outside of the scheduled committee meeting. • Revise the project documents to address the missing information.
Quality Improvement Committee		
The organization has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	
The QI Committee meets at regular intervals	Met	
Minutes are maintained that document proceedings of the QI Committee	Met	
Annual Evaluation of the Quality Improvement Program		
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	
The annual report of the QI program is submitted to the QI Committee	Met	

Care Coordination/Case Management

The Community Health Solutions of America (CHS) Board of Directors has ultimate oversight of Solutions. The Executive Director/Chief Medical Officer reports to the Board of Directors, oversees program operations, and is responsible for ensuring the goals and objectives of SCDHHS and Solutions are aligned. The Solutions Medical Director, which is currently a vacant position being filled on an interim basis by the Chief Medical Officer, provides clinical oversight and decision-making and works closely with the Directors of Care Coordination, who oversee the daily activities of Care Coordinator staff.

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

Waiver due to the Federal Health Emergency for COVID-19; therefore, all contacts with participants, responsible parties, and providers are conducted virtually or by telephone. Participants and caregivers are included in the review and revision of Person-Centered Service Plans.

A review of program policies and other documentation revealed that, overall, program requirements and processes are well documented. It was confirmed that the Care Planning/Monthly Summary Report policy was revised to clearly document the process used to regularly update and evaluate PCSPs according to requirements in the SCDHHS Contract. This was a Quality Improvement Plan from the previous EQR. See *Table 58*.

Table 58: Solutions' Previous Care Coordination/Case Management QIP

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

However, for the current EQR two issues were noted during the policy review: 1.) policies did not address discharge planning for hospitalized participants, and 2.) did not completely document processes for reporting suspected participant abuse, neglect, or exploitation. The review of sample Care Coordination files revealed only one minor issue in that some Growth and Development Assessment forms were not dated.

A comparison of the plans' scores for the standards in the Care Coordination/Case Management section is illustrated in the table that follows. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 59: Care Coordination/Case Management Comparative Data

Standard	Score	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs	Met	**Strengths:** ▶ Newly enrolled participants are provided with comprehensive information about freedom of choice, rights and responsibilities, community resources, reporting fraud, waste, and abuse, etc. ▶ Participant files confirmed staff follow appropriate processes and thoroughly document activities. **Weaknesses:** ▶ Policies did not address discharge planning for hospitalized participants and did not provide complete information about reporting suspected abuse, neglect, or exploitation of a participant. ▶ Some forms in participant files were not dated. **Recommendations:** • Ensure policies completely address required activities. • Ensure all documentation in participant files is dated.
Policies and procedures and/or the program description address the following: Structure of the program	Met	
Lines of responsibility and accountability	Met	
Goals and objectives of Care Coordination/Case Management	Met	
Intake and assessment processes for Care Coordination/Case Management	Met	
Providing required information to participants at the time of enrollment	Met	
Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable	Met	
Processes to develop, implement, coordinate, and monitor individual Person-Centered Service Plans with the participant/caregivers and the PCP	Met	
Processes to ensure caregiver/parent participation in and understanding of the Person-Centered Service Plans	Met	
Process to regularly update and evaluate the Person Centered Service Plans on an ongoing basis	Met ↑	
Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Not Met ↓	
Processes for reporting suspected abuse, neglect, or exploitation of a participant	Partially Met ↓	
A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Met	
The organization provides a written, formal evaluation of the Person Centered Plan to SCDHHS every 6 months or upon request	Met	

Standard	Score	▶ = Quality ▶ = Timeliness ▶ = Access to Care
The organization conducts Care Coordination and Case Management functions as required by the contract	Met	

I. Coordinated and Integrated Care Organizations Annual Review

SCDHHS contracts with three Coordinated and Integrated Care Organizations (CICOs) to provide services for the dual eligible Medicare/Medicaid population in SC. Those organizations include ATC, Molina, and Select Health. For this contract year, CCME conducted an External Quality Review of ATC and Molina. The EQR for Select Health was postponed at the request of SCDHHS and will be conducted in the fall of 2022. The EQR for ATC and Molina focused on network adequacy for home and community-based service (HCBS) and behavioral health providers, over- and under-utilization, and care transitions.

The process used by CCME for the EQR activities is based on the CMS *Protocol 3, Review of Compliance with Medicaid and CHIP Managed Care Regulations*. To conduct the review, CCME requested desk materials from each CICO. These items focused on administrative functions, committee minutes, member and provider demographics, over and under-utilization data, and care transition files.

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

Provider Network Adequacy

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

SCDHHS established minimums for the HCBS of at least two providers for each service in each county except Anderson, Charleston, Florence, Greenville, Richland, and

Spartanburg counties. For these larger counties, the minimum was established as three providers for each service. The minimum number of required providers for each active county was calculated and compared to the number of current providers for seven different services:

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

CCME requested a complete list of all contracted HCBS providers currently in ATC's and Molina's networks. The minimum number of required providers for each county was calculated and compared to the number of current providers for the seven different services. For ATC, there were 41 counties documented as having members. Of the 287 services across 41 counties, 287 met the minimum requirements resulting in a validation score of 100%, which is sustained from last year's rate of 100%.

There were 44 counties that were documented as having enrollment in the MMP Member Demographics 2021 file submitted by Molina in the desk materials. Of the 308 services across 44 counties, 308 met the minimum requirement resulting in a validation score of 100%, which is sustained from last year's rate of 100%. Molina also noted they had contracts in one additional county (Lancaster); however, no members were reported for that county. *Table 60: HCBS Provider Adequacy Results* provides an overview of the network adequacy results for each CICO.

Table 60: HCBS Provider Adequacy Results

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Abbeville			
Adult Day Health	2	4	3
Case Management	2	3	6
Home Delivered Meals	2	4	6
PERS	2	16	20
Personal Care	2	24	46
Respite	2	7	2
Telemonitoring	2	3	3
Aiken			
Adult Day Health	2	N/A	7

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Case Management	2		9
Home Delivered Meals	2		4
PERS	2		17
Personal Care	2		58
Respite	2		5
Telemonitoring	2		3
Allendale			
Adult Day Health	2	2	7
Case Management	2	5	6
Home Delivered Meals	2	2	3
PERS	2	15	17
Personal Care	2	14	43
Respite	2	4	2
Telemonitoring	2	3	4
Anderson			
Adult Day Health	3	4	9
Case Management	3	3	6
Home Delivered Meals	3	3	5
PERS	3	17	22
Personal Care	3	32	69
Respite	3	7	7
Telemonitoring	3	3	4
Bamberg			
Adult Day Health	2	4	9
Case Management	2	5	6
Home Delivered Meals	2	3	4
PERS	2	17	14
Personal Care	2	17	49
Respite	2	5	3
Telemonitoring	2	4	4
Barnwell			
Adult Day Health	2	4	6
Case Management	2	5	7
Home Delivered Meals	2	4	3

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
PERS	2	17	17
Personal Care	2	18	46
Respite	2	5	3
Telemonitoring	2	4	4
Beaufort			
Adult Day Health	2	3	5
Case Management	2	4	9
Home Delivered Meals	2	3	3
PERS	2	16	17
Personal Care	2	16	44
Respite	2	4	5
Telemonitoring	2	4	3
Berkeley			
Adult Day Health	2	4	9
Case Management	2	6	9
Home Delivered Meals	2	3	4
PERS	2	16	18
Personal Care	2	19	47
Respite	2	6	4
Telemonitoring	2	4	4
Calhoun			
Adult Day Health	2	5	10
Case Management	2	4	6
Home Delivered Meals	2	4	3
PERS	2	17	18
Personal Care	2	19	50
Respite	2	3	4
Telemonitoring	2	4	4
Charleston			
Adult Day Health	3	6	10
Case Management	3	6	9
Home Delivered Meals	3	4	10
PERS	3	16	18
Personal Care	3	22	54

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Respite	3	7	4
Telemonitoring	3	4	4
Cherokee			
Adult Day Health	2	3	4
Case Management	2	4	5
Home Delivered Meals	2	2	4
PERS	2	16	18
Personal Care	2	18	43
Respite	2	5	3
Telemonitoring	2	4	5
Chester			
Adult Day Health	2	6	6
Case Management	2	3	3
Home Delivered Meals	2	3	3
PERS	2	16	17
Personal Care	2	23	49
Respite	2	9	6
Telemonitoring	2	3	3
Chesterfield			
Adult Day Health	2	2	6
Case Management	2	3	5
Home Delivered Meals	2	5	4
PERS	2	16	19
Personal Care	2	18	44
Respite	2	5	6
Telemonitoring	2	3	3
Clarendon			
Adult Day Health	2	4	7
Case Management	2	6	8
Home Delivered Meals	2	3	4
PERS	2	17	19
Personal Care	2	18	58
Respite	2	5	6
Telemonitoring	2	3	3

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Colleton			
Adult Day Health	2	5	9
Case Management	2	5	7
Home Delivered Meals	2	4	4
PERS	2	16	18
Personal Care	2	19	42
Respite	2	6	3
Telemonitoring	2	4	4
Darlington			
Adult Day Health	2	2	N/A
Case Management	2	5	
Home Delivered Meals	2	2	
PERS	2	16	
Personal Care	2	21	
Respite	2	5	
Telemonitoring	2	2	
Dillon			
Adult Day Health	2	2	6
Case Management	2	4	6
Home Delivered Meals	2	3	4
PERS	2	19	20
Personal Care	2	17	51
Respite	2	4	6
Telemonitoring	2	3	3
Dorchester			
Adult Day Health	2	3	10
Case Management	2	5	9
Home Delivered Meals	2	3	4
PERS	2	15	18
Personal Care	2	20	46
Respite	2	7	4
Telemonitoring	2	3	4
Edgefield			
Adult Day Health	2	3	3

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Case Management	2	3	4
Home Delivered Meals	2	3	3
PERS	2	16	19
Personal Care	2	16	42
Respite	2	5	3
Telemonitoring	2	2	3
Fairfield			
Adult Day Health	2	5	6
Case Management	2	4	7
Home Delivered Meals	2	4	4
PERS	2	17	17
Personal Care	2	27	64
Respite	2	8	6
Telemonitoring	2	3	3
Florence			
Adult Day Health	3	3	6
Case Management	3	5	6
Home Delivered Meals	3	4	4
PERS	3	19	20
Personal Care	3	24	65
Respite	3	5	6
Telemonitoring	3	3	3
Georgetown			
Adult Day Health	2	4	7
Case Management	2	6	8
Home Delivered Meals	2	3	3
PERS	2	17	19
Personal Care	2	20	57
Respite	2	5	4
Telemonitoring	2	3	3
Greenville			
Adult Day Health	3	5	9
Case Management	3	4	5
Home Delivered Meals	3	4	6

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
PERS	3	18	22
Personal Care	3	33	77
Respite	3	11	7
Telemonitoring	3	5	5
Greenwood			
Adult Day Health	2	4	4
Case Management	2	6	8
Home Delivered Meals	2	3	6
PERS	2	16	19
Personal Care	2	26	59
Respite	2	8	5
Telemonitoring	2	2	3
Hampton			
Adult Day Health	2	3	4
Case Management	2	5	7
Home Delivered Meals	2	3	2
PERS	2	16	14
Personal Care	2	14	34
Respite	2	3	2
Telemonitoring	2	4	4
Horry			
Adult Day Health	2	3	7
Case Management	2	7	7
Home Delivered Meals	2	2	3
PERS	2	17	19
Personal Care	2	19	54
Respite	2	4	4
Telemonitoring	2	2	3
Jasper			
Adult Day Health	2	3	5
Case Management	2	4	7
Home Delivered Meals	2	3	3
PERS	2	16	17
Personal Care	2	16	37

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Respite	2	5	3
Telemonitoring	2	4	4
Kershaw			
Adult Day Health	2	5	9
Case Management	2	5	4
Home Delivered Meals	2	3	4
PERS	2	18	19
Personal Care	2	28	62
Respite	2	10	7
Telemonitoring	2	3	3
Lancaster			
Adult Day Health	2	N/A	6
Case Management	2		4
Home Delivered Meals	2		3
PERS	2		18
Personal Care	2		57
Respite	2		6
Telemonitoring	2		3
Laurens			
Adult Day Health	2	4	4
Case Management	2	6	5
Home Delivered Meals	2	4	7
PERS	2	17	20
Personal Care	2	33	68
Respite	2	10	7
Telemonitoring	2	4	5
Lee			
Adult Day Health	2	5	5
Case Management	2	5	7
Home Delivered Meals	2	3	4
PERS	2	17	20
Personal Care	2	17	56
Respite	2	6	5
Telemonitoring	2	3	3

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Lexington			
Adult Day Health	2	7	9
Case Management	2	6	10
Home Delivered Meals	2	3	3
PERS	2	17	17
Personal Care	2	35	83
Respite	2	9	5
Telemonitoring	2	4	4
Marion			
Adult Day Health	2	3	5
Case Management	2	6	2
Home Delivered Meals	2	3	3
PERS	2	18	19
Personal Care	2	22	57
Respite	2	4	5
Telemonitoring	2	3	3
Marlboro			
Adult Day Health	2	2	5
Case Management	2	3	2
Home Delivered Meals	2	3	3
PERS	2	17	20
Personal Care	2	19	47
Respite	2	5	5
Telemonitoring	2	3	3
McCormick			
Adult Day Health	2	3	5
Case Management	2	3	2
Home Delivered Meals	2	4	4
PERS	2	17	18
Personal Care	2	18	40
Respite	2	5	2
Telemonitoring	2	3	3
Newberry			
Adult Day Health	2	10	8

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Case Management	2	6	8
Home Delivered Meals	2	5	5
PERS	2	17	18
Personal Care	2	27	59
Respite	2	7	4
Telemonitoring	2	3	3
Oconee			
Adult Day Health Care	2	N/A	5
Case Management	2		5
Home Delivered Meals	2		4
PERS	2		21
Personal Care	2		72
Respite	2		4
Telemonitoring	2		4
Orangeburg			
Adult Day Health	2	7	13
Case Management	2	7	9
Home Delivered Meals	2	3	3
PERS	2	17	17
Personal Care	2	25	72
Respite	2	8	4
Telemonitoring	2	4	4
Pickens			
Adult Day Health	2	3	6
Case Management	2	3	5
Home Delivered Meals	2	3	6
PERS	2	17	21
Personal Care	2	31	65
Respite	2	10	7
Telemonitoring	2	4	5
Richland			
Adult Day Health	3	8	12
Case Management	3	6	3
Home Delivered Meals	3	4	4

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
PERS	3	17	17
Personal Care	3	40	87
Respite	3	11	6
Telemonitoring	3	4	4
Saluda			
Adult Day Health	2	3	3
Case Management	2	3	4
Home Delivered Meals	2	4	5
PERS	2	17	18
Personal Care	2	23	50
Respite	2	6	3
Telemonitoring	2	3	3
Spartanburg			
Adult Day Health	3	6	7
Case Management	3	5	5
Home Delivered Meals	3	3	6
PERS	3	17	20
Personal Care	3	32	76
Respite	3	12	7
Telemonitoring	3	5	5
Sumter			
Adult Day Health	2	N/A	10
Case Management	2		3
Home Delivered Meals	2		20
PERS	2		67
Personal Care	2		6
Respite	2		3
Telemonitoring	2		3
Union			
Adult Day Health	2	7	7
Case Management	2	6	2
Home Delivered Meals	2	3	4
PERS	2	16	19
Personal Care	2	25	53

County	Minimum Required	ATC Unique Providers	Molina Unique Providers
Respite	2	9	4
Telemonitoring	2	4	3
Williamsburg			
Adult Day Health	2	4	7
Case Management	2	7	2
Home Delivered Meals	2	4	4
PERS	2	17	19
Personal Care	2	19	53
Respite	2	5	4
Telemonitoring	2	3	3
York			
Adult Day Health	2	N/A	5
Case Management	2		3
Home Delivered Meals	2		3
PERS	2		17
Personal Care	2		56
Respite	2		7
Telemonitoring	2		3
Total that Met Minimum (Sum of all services across the total number of counties with minimum required providers met)		287	308
Total Required (Sum all of services across the total number of counties)		287	308
Percentage MET		100%	100%
VALIDATION DECISION		Met	MET

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

The CICOs are also required to have a network of behavioral health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older) and at least one of the behavioral health providers used to meet the two providers per 50-mile requirement must be a Community Mental Health Center (CMHC). ATC and Molina met these requirements. The following is an overview of the findings.

ATC: Information on BH providers was submitted in the desk materials. The requirements as set forth by the State were compared to submitted information. The Geo Access report provided by Quest Analytics showed that 99.7% of members had access to a psychiatrist and 14 members out of 4,734 did not have access, 99.9% of members have access to a psychologist with one member out of 4,734 without access, 99.9% of members have access to a social worker with one member showing no access, and 99.9% of members with access to a CMHC (using a requirement of one in 50 miles).

Molina: The Quest Behavioral Health report showed 100% of members had access to two behavioral health providers with an at least one CMHC included in that access area. The opioid treatment clinics were accessible to over 90% of members with the exceptions of Allendale County, which showed only 2.9%, and Bamberg County which showed 66.1%. Molina provides transportation for member requiring treatment in those counties. All counties had 100% of members showing access to at least two types of behavioral health providers.

Table 61: Provider Network Adequacy Comparative Data provides an overview of each plan's score for the Provider Network Adequacy section. The table also indicates strengths, weaknesses, and recommendations related to quality, timeliness, and access to care.

Table 61: Provider Network Adequacy Comparative Data

Standard	ATC	Molina	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Provider Network Adequacy			
The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Met	**Strengths:** ▶ The CICOs maintained an adequate network sufficient to provide enrollees with access to a full range of Home and Community Based services in each geographic area.
The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Met	

Evaluation of Over- and Under-Utilization

The CICOs are required to monitor and analyze utilization data to look for trends or issues that may provide opportunities for quality improvement. The over- and under-utilization monitoring focuses on five key indicators: 30-day hospital readmission rates for any

potentially avoidable hospitalization, length of stay for hospitalizations, length of stay in nursing homes, emergency room utilization, and the number and percentage of enrollees receiving mental health services.

ATC's files submitted contained reports on utilization in the five required services, as well as other services. The 30-day readmission rate was below the expected utilization at 13.11% (goal is <14.5%). The Length of Stay – Inpatient rate was well above the goal rate of 6.5 at 14.3 (Q1 and Q2 were extremely high values). The penetration rate for behavioral health services was at 1.4% for the last measurement in October 2021. The Skilled Nursing Facility length of stay and ER utilization trending was not included in the desk materials but was submitted after the onsite.

The files submitted to desk materials by Molina contained reports on utilization in all five required services, as well as other services including care transitions. The rates are monitored, trends are analyzed, and issues are identified. For the length of stay - Hospitalizations, the rate increased from 6.8 to 7.9. For the length of stay for skilled nursing facilities, the rate increased from 18.1 to 19.9. For ED utilization, the total visits increased from 2756 to 3533. The mental health service utilization rate decreased from what was presented for each month. Inpatient admits declined in the most recent measurement from 8.28 per 1000 to 7.05 per 1000. Outpatient services increased from 10.30 to 12.07 per 1000. Overall, the total number of members declined from 878 in 2002 to 840 in 2021.The 30-day readmission rate was submitted after the onsite and reflected a 13.3% rate, which is below the goal of 14%.

The CICOs met the requirements for evaluating over- and under-utilization as shown in *Table 62: Evaluation of Over/Under Utilization Comparative Data*.

Table 62: Evaluation of Over/Under Utilization Comparative Data

Standard	ATC	Molina	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Evaluation of Over/Under Utilization			
The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to: 30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection,	Met	Met	

Standard	ATC	Molina	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
CHF, Dehydration, COPD/Asthma, and Skin Ulcers)			
Length of stay for hospitalizations	Met	Met	
Length of stay in nursing homes	Met	Met	
Emergency room utilization	Met	Met	
Number and percentage of enrollees receiving mental health services	Met	Met	

Care Transitions

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

ATC: CCME reviewed 36 files for members who were readmitted within 30 days of a hospital discharge and noted an overall improvement in the frequency of interdisciplinary care team meetings. Files reflected staff make multiple attempts to contact members after discharge, including attempting to get additional or alternate contact information from providers, facilities, etc. Overall, the files included documentation of clinical and non-clinical barriers and support.

Issues identified through the file review included:

- Lack of documentation of interaction with facility Case Managers or Discharge Planners was noted for six files.
- Lack of documentation of collaboration with the PCP was noted for seven files.
- For five files, attempts to contact members/caregivers within 72-hours of discharge was untimely or was not conducted.
- Lack of documentation of a full assessment post discharge was noted for 13 files. It was noted that Policy SC.CM.24, Discharge Planning and Outreach – MMP, indicates "A subsequent HRA and ICT meeting is scheduled if hospitalization resulted from change in condition or functional status" and that if "admission resulted in minor changes in health condition" the Care Coordinator may update only applicable components of the

health risk assessment specific to the condition in a clearly documented outreach note. However, the *CICO Three-Way Contract, Section 2.6.3.9.4,* requires the CICO to conduct a reassessment and ICP update upon any of the following trigger events: hospital admission, care setting transition, change in functional status, loss of caregiver, changes in or additions of a diagnosis, and if requested by the member of the multidisciplinary team.

- In some file notes, the admission and discharge date fields were not completed, making it difficult to associate the note to a particular admission event.

Four of the five issues identified in the files reviewed for the current EQR (2021) were repeat findings from the previous EQR (2020). See *Table 63: ATC's Previous Care Transitions Quality Improvement Items*, for ATC's response to the previous year's findings.

Table 63: ATC's Previous EQR Care Transitions Quality Improvement Items

Standard	EQR Comments
III. Care Transitions	
1. The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions.	CCME reviewed 32 files for members who were readmitted within 30 days of discharge from a hospital. CCME noted an overall improvement in notifications of admissions and discharges between Utilization Management and Care Management staff, and between ATC and the healthcare facilities. The following recurring documentation issues were identified: •16 files (50%) did not reflect a reassessment was conducted after a change in the member's status. •14 files (44%) did not have clinical follow-up within 72 hours of the member's transition. •10 files (31%) did not reflect outreach to the PCP. •10 files (31%) did not reflect contact with the facility's discharge planner. •7 files (22%) did not reflect Medication Monitoring and Adherence was assessed. During the virtual onsite, ATC acknowledged the identified issues and noted opportunities were missed. Improvement strategies, such as transitioning all TOC staff into one team, retraining staff, and continuing collaboration with Provider Relations staff were established to address areas of low performance. *Quality Improvement Plan: In order to comply with requirements in the CICO 3-Way Contract, Section 2.6.9.7, ensure members are reassessed after a change in status and clinical follow-up is conducted within 72-hours of transition. Continue to implement and evaluate improvement processes that address communication barriers between the health plan and facilities, and between internal departments (CM, UM, etc.). Ensure files contain documentation of all communication with the PCP's office and documentation of medication monitoring.*

Standard	EQR Comments
ATC Response: 1. Communication between internal/external departments, health plan and facilities: • ATC's UM team will identify readmissions and send notification tasks to the TOC team to initiate the TOC process. Immediate implementation. • ATC's TOC team will send tasks to primary CM alerting of readmission and discharge. Immediate implementation. • See below for auditing #6. 2. Files contain documentation of PCP notification: • The TOC team will ensure timely outreach by: • Review of tasks from UM team and initiate outreach to facility discharge planner and member's PCP within outlined timelines. • Notify member's PCP of discharge within outlined timelines. • Implement above processes immediately. • See below for auditing #6. 3. Clinical follow-up within 72 hrs. of discharge is conducted: • ATC's TOC team will review inpatient daily census and discharge reports to identify discharges as soon as possible and engage in clinical follow up with the 72 hr. outreach guidelines. • See below for auditing #6. 4. Files contain documentation of medication reconciliation post-discharge: • Primary CM will review discharge notification task sent by TOC team and complete member reassessment and medication reconciliation within 30 days of discharge to home/permanent placement. • Implement immediately. • See below for auditing #6 5. Members reassessed after a change in Status: • Primary CM will receive task/email from TOC team informing of discharge to home. • Primary CM will outreach to member and complete reassessment. • Update Care plan and notes. • Implement above immediately. • See below for auditing #6 6. MMP and TOC Managers will review cases weekly for timeliness of TOC process and reassessment. If deficiencies are found: • Managers will retrain individuals and teams, immediately. • Coaching/performance improvement plans will be developed for individuals with reoccurring deficiencies per human resources policies and procedures.	

From December 2020 to November 2021, 1,225 of ATC's MMP members experienced a transition of care. Of the 1,225 members, 154 (13%) transitioned to a higher level of care. CCME could not identify documentation that ATC analyzed or reviewed the 154 transitions to a higher level of care to identify barriers, improvement opportunities, or any actions taken to improve outcomes.

Molina: CCME reviewed a sample of TOC files. The following issues were identified:

- There were some calls documented to check on the member's inpatient status, but very few instances of collaboration with facility Case Management or Discharge Planning staff to ensure safe transition were documented.

- Primary care provider (PCP) notifications of admission and discharge were inconsistent. Some files had no documentation of notification, while others stated the PCP could not be notified due to no PCP on file, etc. Some files indicated the TOC/CM staff would work to engage the member with a PCP, but no further action was documented.
- Documentation of identified clinical and non-clinical supports needed, transition/aftercare appointments, and new barriers to after-care was lacking in most files.
- Some files had no documented attempts to contact the member to conduct the 72-hour follow-up post discharge. For several files that did include documented attempts to conduct the 72-hour follow-up, many of the first attempts were outside of the 72-hour window.
- Few files included documentation of a post-discharge assessments. Molina documented that some of the members could not be contacted, but for others, there was no explanation included in the file.

Molina staff reported during the onsite that for any readmission, quality screening and TOC monitoring are conducted to ensure the appropriateness of transitions. Molina also reported that in 2021, MMP Case Management staff were moved from the local plan team into the corporate team, allowing for robust leadership and more centralization of activities.

CCME found issues with the file review for both CICOs. *Table 64: Care Transitions Comparative Data* shows ATC received "Partially Met" scores for the handing of care transitions and for a lack of documentation analyzing transitions that resulted in a higher level of care to identify barriers or improvement opportunities. Molina's "Partially Met" score was due to their handling of care transitions.

Table 64: Care Transitions Comparative Data

Standard	ATC	Molina	▶ = *Quality* ▶ = *Timeliness* ▶ = *Access to Care*
Care Transitions			
The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions	Partially Met	Partially Met ↓	**Strengths:** ▶ All the CICOs had policies and processes established to conduct appropriate transition of care (TOC) functions as required by the *SCDHHS Contract*. **Weaknesses:** ▶ ATC and Molina continue to have transition of care issues. Files lacked documentation of the required follow-up assessments, reassessments, PCP notifications, and collaboration with facility Case Management or Discharge Planning staff. ▶ ATC - Transitions that result in a move to a higher level of care are not analyzed to determine factors that contributed to the change and actions needed to improve outcomes. **Recommendations:** • Ensure all TOC functions required by the *SCDHHS Contract, Sections 2.5 and 2.6* are conducted and clearly documented in the members' files. • CICOs should collect and analyze the data for transitions that result in a higher level of care to identify contributing factors and improvement opportunities.
Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes	Partially Met ↓	Met	

FINDINGS SUMMARY

Overall, Select Health sustained or showed the most improvements in six areas followed by Molina in five areas. *Table 65: Annual Review Comparisons* reflects the total percentage of standards scored as "Met" for the 2020 through 2022 EQRs. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings. Areas reviewed for the MCOs that are not applicable for Solutions and for Humana's Readiness Review conducted in 2021 are noted as Not Applicable (NA).

Table 65: Annual Review Comparisons

	ATC		HEALTHY BLUE		Humana		MOLINA		SELECT HEALTH		SOLUTIONS	
	2020	2021	2021	2022	**2021	2022	2020	2021	2020	2021	2021	2022
Administration	100%	100%	100%	100%	80%	95%	100%	100%	100%	100%	100%	97%
Provider Services	99%	97%	96%	99%	91%	85%	95%	99%	95%	96%	100%	100%
Member Services	100%	100%	100%	97%	91%	95%	97%	100%	97%	100%	NA	NA
Quality Improvement	100%	100%	100%	100%	77%	91%	100%	93%	100%	100%	100%	100%
*Utilization Management	100%	98%	100%	96%	86%	86%	98%	93%	98%	100%	93%	87%
Delegation	100%	100%	50%	50%	50%	100%	50%	100%	50%	100%	NA	NA
State Mandated Services	75%	75%	75%	75%	NA	25%	75%	100%	75%	75%	NA	NA

*Care Coordination/Case Management for Solutions

***Humana's first EQR was in 2022. 2021 was a Readiness Review*

Regarding 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*, Select Health sustained or showed the most improvement in nine of the 10 categories, followed by ATC. Healthy Blue and Molina sustained or showed improvements in six of the 10 categories. *Table 66: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons* reflects the total percentage of standards scored as "Met" for the 2019 through 2022 EQRs. For the most recent reviews, the percentages with up arrow (↑) indicate improvement over the prior year's review findings. Those with a down arrow (↓) represent a reduction in the prior review findings.

Table 66: Compliance with 42 CFR Part 438 Subpart D Annual Review Comparisons

		Availability of Services and Assurances of Adequate Capacity and Services	Coordination and Continuity of Care	Coverage and Authorization of Services	Provider Selection	Confidentiality	Grievance and Appeal Systems	Sub-contractual Relationships and Delegation	Practice Guidelines	Health Information Systems	Quality Assessment and Performance Improvement Program
ATC	2021	75%↓	100%	92.8%↓	100%	100%	100%	100%	100%	100%	100%
	2020	87.5%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	2019	87.5%	100%	92.8%	87.8%	100%	95%	100%	100%	100%	100%
HEALTHY BLUE	2022	87.5%	100%	92.8%↓	100%↑	100%	90%↓	50%	100%	100%	100%
	2021	87.5%	100%	100%	94.8%	100%	95%	50%	100%	100%	100%
	2020	100%	100%	100%	92.6%	100%	85%	50%	100%	100%	100%
*HUMANA	2022	**100%	100%	78.5%	76.9%	0%	90%	100%	100%	100%	**90.9%
MOLINA	2022	87.5%↑	100%	92.8%↓	100%	100%	90%↓	100%	100%	100%	92.8%
	2021	62.5%	100%	100%	100%	100%	100%	100%	100%	100%	92.8%
	2020	100%	100%	100%	100%	100%	100%	100%	100%	100%	85.7%
SELECT HEALTH	2021	75%	100%↑	100%	100%↑	100%	100%	100%↑	100%	100%	100%
	2020	75%	87.5%	100%	94.8%	100%	100%	50%	100%	100%	100%
	2019	87.5%	100%	100%	100%	100%	100%	50%	100%	100%	100%

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

**Humana's first EQR was in 2022. 2021 was a Readiness Review*

***The Standards Not Evaluated were removed from the denominator and numerator*