CCME

2017 External Quality Review

SELECT HEALTH OF SOUTH CAROLINA

Submitted: December 8, 2017

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

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. The purpose of this review was to determine the level of performance demonstrated by Select Health of South Carolina (Select Health) since the 2016 annual review. This report contains a description of the process and the results of the 2017 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

Goals of the review were to:

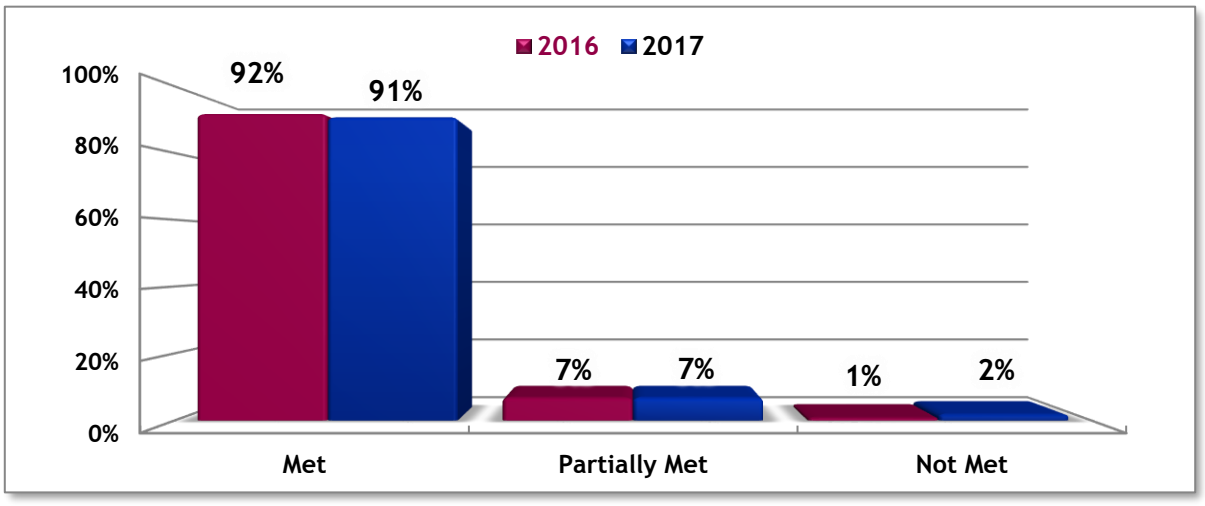
- Determine if Select Health was in compliance with service delivery as mandated in the MCO contract with SCDHHS.
- Evaluate the status of deficiencies identified during the 2016 annual review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Assure that contracted health care services are actually being delivered and are of good quality.

The process used for the EQR was based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review included a desk review of documents, a two-day onsite visit, a telephone access study, compliance review, validation of Performance Improvement Projects (PIPs), validation of performance improvement measures and validation of satisfaction surveys.

Overall Findings

The 2017 annual EQR review shows that Select Health has achieved a “Met” score in 91% of the standards reviewed. As the following chart indicates, 7% of the standards were scored as “Partially Met,” and 2% of the standards scored as “Not Met.” The chart that follows provides a comparison of Select Health’s current review results to the 2016 review results.

Figure 1: Annual EQR Comparative Results



An overview of the findings for each section follows. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items and recommendations can be found further in the narrative of this report.

Administration:

Policies and procedures are detailed and reviewed annually, which is clearly documented in all policies. Staffing and leadership personnel levels appear adequate to ensure Select Health can provide all health care products and services required by the contract with SCDHHS. Select Health's compliance program is comprehensive and numerous policies address program integrity, including fraud, waste, and abuse (FWA).

The Information Systems Capability Assessment (ISCA) documentation and supporting materials confirm exceptional claims payment statistics; systems and processes are in place to adequately collect, report, and process data required by the *SCDHHS Contract*; electronic transactions meet or exceed requirements; a secure operating environment is evident with a focus on data security; and there are successful results from the annual disaster recovery and business continuity tests.

Provider Services:

Dr. Greg Barabell, Market Chief Medical Officer (CMO), chairs the Credentialing Committee. The committee chair votes only in place of a tie and a quorum is met with over 50% of the voting members in attendance; however, a review of committee minutes revealed the quorum was not met at four meetings.

The *Credentialing Program 2017* document and multiple policies address the credentialing and recredentialing processes. Several issues were noted such as inconsistent information between documents, and the Exclusion and Termination for Cause List is not documented as a query requirement. The credentialing/recredentialing file review showed no evidence of the following queries: the Exclusion and Termination for Cause List and the Social Security Death Master File (SSDMF).

The appointment availability surveys, conducted by Select Health for primary care providers (PCPs) and high volume/high impact specialists, showed low compliance for the specialists collectively, which did not meet the 95% goal. While the goal was met for PCPs, new patient routine and urgent care standards showed low compliance rates. The behavioral health appointment access study showed low compliance for non-life threatening emergent care, while urgent, routine, and post-discharge follow-up care met availability timeframes.

Member Services:

Members can contact the Member Services Call Center during normal business hours, and can leave a message after hours for a response the next business day. The Nurse Help Line is available around the clock. Translation/interpretation services are available 24-hours a day by contacting either Member Services or the Nurse Help Line.

The *Member Handbook* is comprehensive and provides most of the information needed for members to understand the plan and available benefits, although a few revisions are recommended to ensure complete information is provided.

Response rates to the adult and child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) surveys increased slightly, and recommendations were offered to try to improve the response rates for future surveys. Select Health developed interventions and initiatives to improve problem areas identified during the surveys.

An area of concern is a repeat deficiency related to holding members liable for emergency services received at an out-of-network facility.

Quality Improvement:

Select Health has procedures and processes in place for measuring and improving the care and services its providers render to its members.

The comparison from the previous to the current year Healthcare Effectiveness Data and Information Set (HEDIS®) revealed a strong increase in Metabolic Monitoring for Children and Adolescents on Antipsychotics for children ages 1 to 5. The most problematic measures were Statin Therapy for Patients with Cardiovascular Disease and Follow-Up

After Hospitalization for Mental Illness, which decreased substantially from last year. A performance improvement project has been established for the follow-up after hospitalization measure.

Two projects were validated using the CMS Protocol for Validation of Performance Improvement Projects. They included Diabetes Outcomes Measures and Follow-Up After Hospitalization for Mental Health Within 7 and 30 Calendar days After Discharge. The diabetes project received a validation score within the High Confidence level and the hospitalization follow-up project was scored within the Confidence level.

Utilization Management:

Select Health has developed program descriptions and policies to guide staff in the performance of utilization management (UM) functions.

Consistency in clinical criteria application and uniformity in decision-making exceeds thresholds based on routine inter-rater reliability (IRR) testing processes. Certified InterQual instructors are on staff to provide initial and on-going training for medical criteria interpretation and application. Both physician and non-physician clinical reviewers participate in IRR testing.

Although Select Health staff reported the implementation of a program to meet contractual requirements for a Preferred Provider Program, no documentation was provided to support the compliance of the program to requirements in the *SCDHHS Contract*.

Delegation:

Select Health delegates credentialing functions to multiple entities; utilization management and provider call center functions to National Imaging Associates (NIA); and nurse triage services to Citra Health Solutions. Processes are in place for delegation initiation and oversight; however, Select Health received "Partially Met" scores for both standards in the Delegation section. This was due to outdated contract language in Policy CR.101.SC, Delegation of Credentialing and Recredentialing Activities and the attached exhibits. In addition, the annual oversight for delegated credentialing reflected issues such as the SC Medicaid audit tool containing outdated contract language, the file review tool not containing SC-specific requirements, ownership disclosure forms were not checked for two delegated entities, and one delegated entity did not have a file review completed. As a result, it was difficult to determine how SC credentialing requirements were taken in to consideration.

State Mandated Services:

Providers are monitored for compliance with provision of Early and Periodic Screening, Diagnostic and Treatment (ESPDT) services and administration of immunizations via medical record review and in conjunction with the annual HEDIS survey. Various methods are used to inform providers of needed services, including quarterly mailings of members due for services and face-to-face quarterly meetings with provider account executives. In addition, two provider portals offer the ability to view specific member's care gaps.

Select Health received a score of "Not Met" for one grievance standard due to an uncorrected deficiency from the previous EQR.

*Table 1, Scoring Ov*erview provides an overview of the findings of the current annual review as compared to the findings of the 2016 review.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2016	33	0	0	0	0	33
2017	39	0	0	0	0	39
Provider Services						
2016	67	7	1	0	0	75
2017	69	7	2	0	0	78
Member Services						
2016	34	3	0	0	0	37
2017	31	1	1	0	0	33
Quality Improvement						
2016	14	0	1	0	0	15
2017	14	1	0	0	0	15
Utilization						
2016	34	4	0	0	0	38
2017	40	5	0	0	0	45

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Delegation						
2016	2	0	0	0	0	2
2017	0	2	0	0	0	2
State Mandated Services						
2016	3	0	1	0	0	4
2017	3	0	1	0	0	4

METHODOLOGY

The process used by CCME for the EQR was based on CMS-developed protocols for Medicaid MCO/ Prepaid Inpatient Health Plan (PIHP) EQRs and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On September 25, 2017, CCME sent notification to Select Health that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Select Health to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Select Health on October 9, 2017, and reviewed in CCME's offices (see Attachment 1). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Utilization Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was an onsite review conducted on November 9, 2017 and November 10, 2017 at the Select Health office in Charleston, SC. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

EQR findings are summarized in the following table and are based on the regulations set forth in *42 Code of Federal Regulations (CFR) 438.358* and the *SCDHHS Contract*. Strengths, weaknesses, and recommendations are identified where applicable. We identify areas of review as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated" on the tabular spreadsheet (Attachment 4).

A. Administration

The administration review focuses on the health plan's policies and procedures, staffing, information systems, compliance, and confidentiality. Policies and procedures are detailed and reviewed annually, as clearly stated in all policies. Rebecca Engelman, Market President, has responsibility for the day-to-day business activities. Dr. Greg Barabell, Medical Director and Market CMO, is board certified in pediatrics. Dr. Roger Beardmore, Medical Director, is a SC-licensed psychologist and is approved by SCDHHS to lead behavioral health. Staffing and leadership personnel levels appear adequate to ensure Select Health can provide all health care products and services required by the *SCDHHS Contract*.

Select Health's ISCA documentation indicates that the necessary systems and processes are in place to adequately collect, report, and process data required by the *SCDHHS Contract*. This MCO's focus on security, audits, and disaster recovery plans are exemplary per the provided documentation. Select Health exceeds the requirements for paying claims set by the *SCDHHS Contract*.

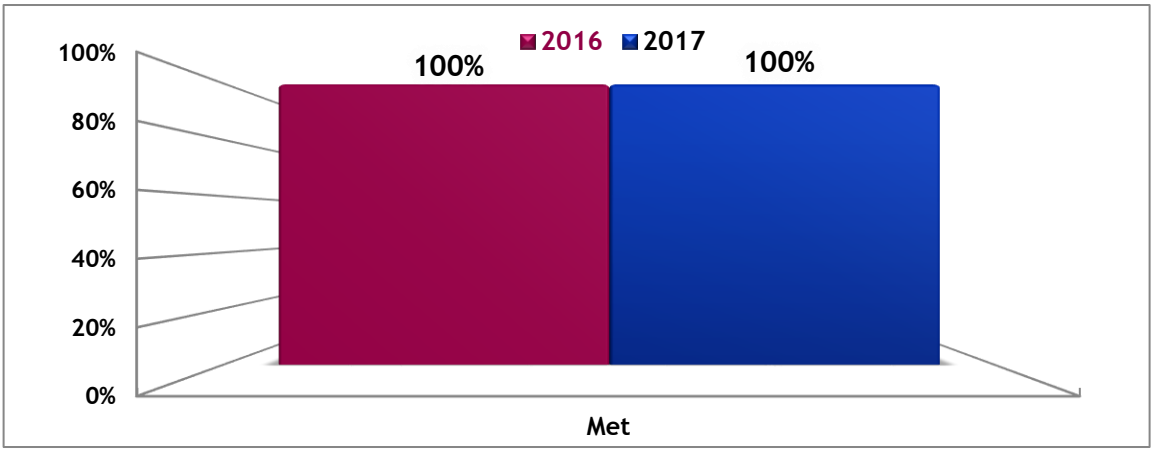
Errors or discrepancies in the enrollment data are identified in the claims processing system. If an error or discrepancy is detected, Select Health has policies and procedures to report the error to members of their enrollment department as well as tools and processes to resolve the data duplication and communicate the issue to the SCDHHS.

Select Health is a member of the AmeriHealth Caritas family of companies. Select Health has an established Compliance Committee, which is supported by resources from the AmeriHealth Caritas Corporate Compliance Program. AmeriHealth Caritas has also established an enterprise-wide program integrity initiative tasked with preventing, detecting, investigating, and mitigating FWA. The Special Investigations Unit (SIU) is responsible for detecting and preventing FWA throughout the claims payment processes for all AmeriHealth Caritas lines of business, including Select Health.

Select Health's compliance program is comprehensive and numerous policies address program integrity, including FWA.

Select Health received "Met" scores for 100% of the standards in the administration section.

Figure 2: Administration Findings



Strengths

- Select Health focuses on data security, audits, assessments, and disaster recovery tests.
- Select Health has exceptional claims payment statistics and thorough documentation on all systems.

B. Provider Services

A review of Select Health's policies and procedures, the provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines was conducted for provider services.

Dr. Greg Barabell, Market Chief Medical Officer (CMO) chairs the Credentialing Committee, and current voting members include the regional CMO, five Select Health Medical Directors, and eight network providers with the specialties of pediatrics, family practice, OB/GYN, and orthopedic surgery. The committee chair votes only in place of a tie and a quorum is met with over 50% of the voting members in attendance. A review of committee meeting minutes shows the quorum was not met in the following four meetings: October 26, 2016, November 30, 2016, May 31, 2017, and June 28, 2017. The Credentialing Committee minutes are very detailed; however, they do not indicate if a voting quorum has been established.

The *Credentialing Program 2017* and multiple policies address the credentialing and recredentialing processes. Several issues were noted such as incorrect policy references, inconsistent information between the *Credentialing Program 2017* and some policies, and

the documents do not address the need for querying the Exclusion and Termination for Cause List as required in the *SCDHHS Policy and Procedure (P&P) Guide*. Select Health did confirm onsite they are performing the queries as required, but the file review did not reflect evidence of the query. Overall the credentialing/recredentialing files were in good order; however, there was also no evidence in the files that the Social Security Death Master File (SSDMF) had been queried.

Network accessibility reports were received and showed that appropriate standards for measuring access were applied. Select Health has a solid network with access that exceeds contract requirements.

Select Health conducted appointment availability surveys for PCPs and high volume/high impact specialists, and results showed low compliance for the specialists collectively, which did not meet the 95% goal. PCPs did meet the 95% goal, but appointment access for new patient routine care and new patient urgent care showed low compliance rates. The rate for emergency care for a new member was just below the plan standard.

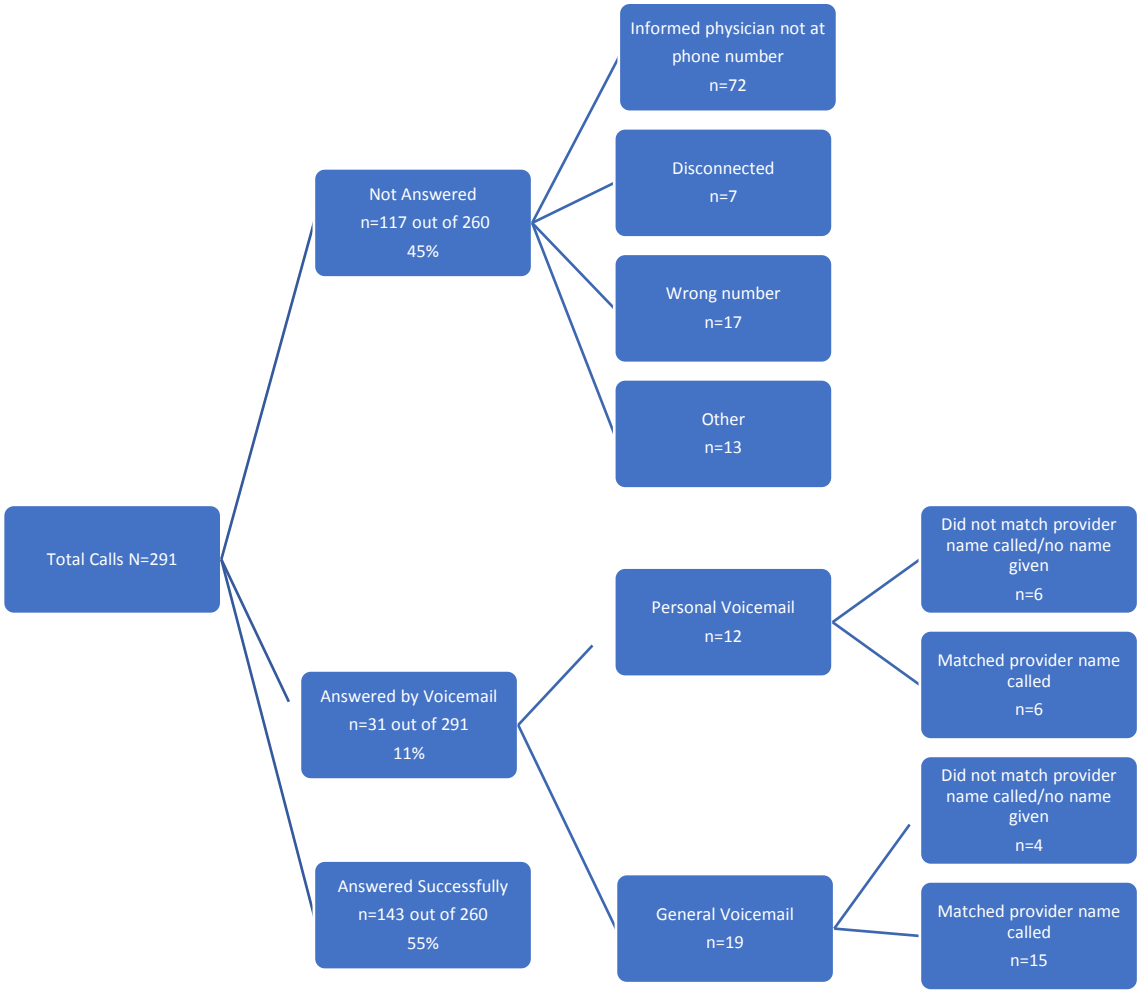
Select Health conducted a behavioral health appointment access study with results reported in the Quality Assessment and Performance Improvement (QAPI) 2016 program evaluation. While urgent, routine, or post-discharge follow-up care met availability timeframes, 52% of the providers did not meet the timeframe for non-life threatening emergent care.

Provider Access and Availability Study

As part of the annual EQR process for Select Health, a provider access study was performed focusing on primary care providers. Select Health provided a list of current providers, from which a population of 2,356 unique PCPs was found. A sample of 291 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 that members have with the contracted providers.

In reference to the results of the telephone provider access study conducted by CCME, calls were successfully answered 55% of the time (143 out of 260) when omitting calls answered by personal or general voicemail messaging services (see *Figure 3*).

Figure 3. Provider Access Study Results



When compared to last year's results of 39%, this year's study had a statistically significant increase in successful calls ($p<.01$).

For those not answered successfully (n=117 calls), 72 (62%) were unsuccessful because the provider was not at that office or phone number listed. Of the 143 successful calls, 118 (83%) of the providers indicated that they accept Select Health, although six (4%) indicated that this occurred only under certain conditions. And of the 118 that accept Select Health, 91 (77%) responded that they are accepting new Medicaid patients.

Regarding a screening process for new patients, 40 (45%) of the 88 providers that responded to the item indicated that an application or prescreen was necessary. Of those 40, 14 (35%) indicated that an application must be filled out whereas five (13%) require a

review of medical records before accepting a new patient, and 13 (33%) required both. When the office was asked about the next available routine appointment, 67 (84%) of the 80 responses met contract requirements.

While results of the telephone provider access study showed improvement, for calls that were sent to voicemail it was noted that some of the personal voicemail messages did not match the provider name with the number listed. CCME would recommend the plan explore ways for providers to report and update incorrect contact information.

Figure 4, Provider Services Findings shows that 88% of the standards in Provider Services received a "Met" score.

Figure 4: Provider Services Findings

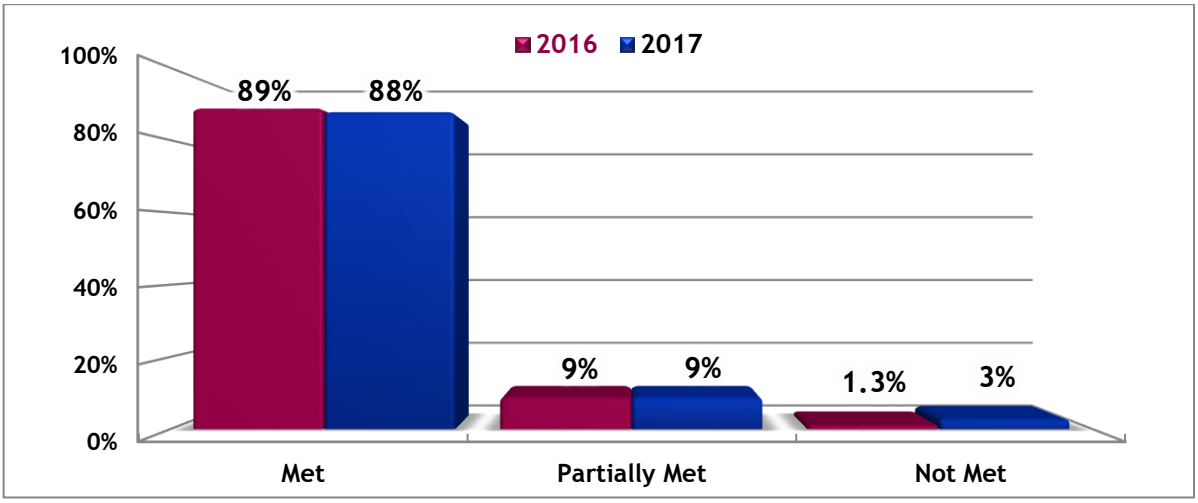


Table 2: Provider Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	Credentialing: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Partially Met
	Recredentialing: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Met	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Credentialing and Recredentialing	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	Partially Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Met	Partially Met
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Partially Met	Met
	The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Partially Met	Met
	The MCO maintains a provider directory that includes all requirements outlined in the contract	Partially Met	Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Provider access study success rates increased with the new calculation formula for success rate.
- Select Health conducts an annual screening of ownership disclosure forms for all credentialed providers/facilities and requests updated forms when ownership changes are identified.
- New provider education includes an orientation with comprehensive materials conducted by account executives. In addition, ongoing training includes regional training sessions and webinars, and the Select Health website provider portal contains good resource information.

Weaknesses

- The Exclusion and Termination for Cause List is not mentioned in the credentialing program description, *Provider Manual* or any of the policies. (Reference *SCDHHS Policy and Procedure (P&P) Guide, Section 11.1.*) Onsite discussion confirmed the list is being checked as required.
- Policy CR.112.SC, Credentialing/Recredentialing Provider Denial, Termination or Reconsideration Appeal Process references policy QM 154.300 and should reference QM 154.010.
- Policy CR.112.SC defines that the Credentialing Committee reviews reconsiderations and if a provider appeals, then the Medical Director (who chairs the Credentialing Committee) will select members for a professional review committee and identify a chair person for the appeal hearing. However, page 12 of the *Provider Manual* states the QAPIC Committee reviews provider appeals. Onsite discussion confirmed the *Provider Manual* is incorrect.
- A review of Credentialing Committee meeting minutes shows the quorum was not met in the following four meetings: October 26, 2016, November 30, 2016, May 31, 2017, and June 28, 2017. The Credentialing Committee minutes are very detailed; however, they do not indicate if a voting quorum has been established.
- The following was identified in the credentialing and recredentialing file reviews:
  - Credentialing and recredentialing files reviewed did not contain evidence the Exclusion and Termination for Cause List had been queried.
  - The credentialing and recredentialing file review did not include evidence the SSDMF had been searched. Onsite discussion confirmed that Select Health is currently implementing a process to query the SSDMF.
- Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality has an incorrect policy reference. It refers to policy QI 154-300, Review of Potential Quality of Care Concerns, which is no longer an active policy.
- Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process and the *Credentialing Program 2017* had the following issues/discrepancies:
  - Page 19 of the *Credentialing Program 2017*, Section 2c, has a paragraph related to the DHHS program integrity unit and the Medicaid Fraud Control unit that is not mentioned in page 2 of the Policy CR.103.SC, Section 1.
  - Page 24 of the *Credentialing Program 2017*, #20, has updated information that is not listed on page 6 of Policy CR.103.SC regarding the DHHS Program Integrity unit and the Medicaid Fraud Control Unit. In addition, it states that no appeal process is afforded to providers during initial credentialing in #22 and this is not listed in Policy CR.103.SC.

  - Pages 25 of the *Credentialing Program 2017*, #7, has updated information that is not listed on page 7 of Policy CR.103.SC, #6a, regarding the DHHS Program Integrity unit and the Medicaid Fraud Control Unit.
  - Pages 3 and 7 of Policy CR.103.SC discuss required queries but do not specifically mention the SC Excluded Provider List or the Exclusion and Termination for Cause List.
- Policy CR.104.SC, Ongoing Monitoring-Licensure and Medicare/Medicaid Sanctions does not address the monitoring of the Exclusion and Termination for Cause List that is required in the *SCDHHS P&P Guide*, Section 11.1.
- Page 28 of the *Credentialing Program 2017* has a section for ongoing monitoring that mentions some required queries but does not mention the SC State Excluded Provider List or the Exclusion and Termination for Cause List.
- Results of the appointment availability surveys conducted by Select Health for PCPs and high volume/high impact specialists showed low compliance for the specialists that did not meet the 95% goal. PCPs did meet the 95% goal, but appointment access for new patient routine care and new patient urgent care showed low compliance rates. The rate for emergency care for a new member was just below the plan standard.
- Select Health conducted a behavioral health appointment access study with results reported in the *QAPI 2016 Program Evaluation*. While urgent, routine, or post-discharge follow-up care met availability timeframes, 52% of the providers did not meet the timeframe for non-life threatening emergent care.
- Page 16 of *QAPI 2016 Program Evaluation* incorrectly lists the behavioral health standard for urgent care as "within 10 business days" when it should reflect "within 48 hours."
- While results of the telephone provider access study conducted by CCME showed improvement, for calls that were sent to voicemail it was noted that some of the personal voicemail messages did not match the provider name with the number listed. CCME would recommend the plan explore ways for providers to report and update incorrect contact information.
- Several practice guidelines such as ADHD-children and adolescents, adult ADHD, and depression in adults address behavioral health; however, it does not appear that Select Health has adopted guidelines to address substance abuse.

Quality Improvement Plans

- Update the credentialing program description, applicable policies/*Provider Manual* to reflect that the Exclusion and Termination for Cause List is being reviewed at initial credentialing, recredentialing, and monthly.

- Remove the incorrect policy reference in Policy CR.112.SC. The policy references policy QM 154.300 and should reference QM 154.010.
- Correct the discrepancy between Policy CR.112.SC and the *Provider Manual* regarding which committee reviews provider appeals.
- Ensure a quorum has been established at each Credentialing Committee meeting.
- Credentialing and recredentialing files should contain evidence of query of the Exclusion and Termination for Cause List.
- Ensure credentialing and recredentialing files include proof of query of the SSDMF.
- Update Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality to remove the QI 154-300 policy reference.
- Update the *Credentialing Program 2017* and/or Policy CR.103.SC to reflect consistent information regarding organizational providers.
- Ensure Policy CR.103.SC specifies the required queries instead of using general terms.
- Update Policy CR.104.SC, Ongoing Monitoring-Licensure and Medicare/Medicaid Sanctions to address the process of monitoring the Exclusion and Termination for Cause List on a monthly basis. Also, update the *Credentialing Program 2017* to address the monitoring of the SC State Excluded Provider List and the Exclusion and Termination for Cause List in the ongoing monitoring section.

Recommendations

- Continue to assess barriers and implement interventions to address the low results of the PCP and specialty (high volume, high impact) accessibility surveys.
- Implement interventions to address the low results for non-life threatening emergent care identified in the 2016 behavioral health appointment access study.
- Update page 16 of the *QAPI 2016 Program Evaluation* which incorrectly lists the standard for urgent care as "within 10 business days" when it should reflect "within 48 hours."
- Regarding the telephone provider access study conducted by CCME, consider some of the following action steps:
  - Investigate voicemail responses, as some of the personal voicemail messages did not match the provider name with the number listed.
  - Provide a way for enrollees to report a provider contact number that is inaccurate.
  - Provide a simple Web interface for providers to update their current contact information.
- Consider adopting practice guidelines that address substance abuse.

C. Member Services

Select Health's Member Services Call Center is available via a toll-free telephone number and Text Telephone (TTY) services Monday through Friday from 8:00 a.m. to 9:00 p.m., and from 8:00 a.m. to 6:00 p.m. on Saturday and Sunday. Holiday coverage is provided by a rotating schedule. Outside of normal operating hours, members have the option to leave a message for Member Services, and they will receive a response within one business day. Members may also speak with the Nurse Help Line, available 24 hours a day, seven days a week.

Select Health's policy is to send the *Member Handbook* and other new member materials (such as the Notice of Privacy Practices, *Co-payment Reference Guide*, and *Quick Start Guide*) within 30 days of receiving enrollment information from SCDHHS. Onsite discussion revealed these items are usually sent within one week of receiving the enrollment data. Member identification (ID) cards are issued by the 15th day of the month in which the member is enrolled. The *Member Handbook* defines member rights and responsibilities, and members are informed annually through the member newsletter and Select Health's website of the process to obtain a copy of member rights and responsibilities information. The *Member Handbook* includes the information required by the *SCDHHS Contract*; CCME recommended additional information that would be helpful to members. Members are notified of changes or updates to the *Member Handbook* via the Member Handbook List of Changes found on Select Health's website.

During onsite discussion, Select Health staff stated member materials are written at 6th grade reading level and defined the methods used to determine the reading level. A policy addressing the requirements for member materials defined in the *SCDHHS Contract*, *Sections 3.16.1.2* and *3.16.1.3* was not found. Although staff stated they believed a policy is in place and would submit the policy to CCME for review, no policy has been received.

A certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor conducts Select Health's annual member satisfaction surveys. Survey response rates for 2017 showed only a slight increase over the 2016 response rates—from 23% to 24% (Child) and from 20% to 21% (Adult). CCME offered recommendations to try to increase the response rates for future surveys. Survey results were analyzed, and interventions and initiatives were developed by the Quality Management and Utilization Management Departments, and the Quality Assurance Performance Improvement Committee, to address identified areas of focus.

Grievance processes and requirements were documented appropriately in policy, in the *Member Handbook*, and in the *Provider Manual*. Review of grievance files revealed an area of concern due to an inappropriate resolution in which the member was informed he was financially liable for an emergency room visit at an out-of-network facility. The

resolution letter indicated the provider did not obtain authorization; however, as noted in Select Health policy and the *Member Handbook*, emergency services do not require prior authorization. Also, the *SCDHHS Contract*, *Section 4.2.11.1* requires that "the Contractor shall provide emergency services without prior authorization" and "promptly pay for emergency services regardless of whether the Provider has a contract with the Contractor consistent with 42 CFR § 438.114 (c)(1)(i)." This was an issue identified during the previous EQR.

As noted in *Figure 5, Member Services Findings*, 94% of the standards for Member Services received a score of "Met." One standard was scored as "Partially Met" due to lack of a policy addressing contractual requirements for member materials. One score of "Not Met" resulted from the uncorrected issue regarding inappropriate grievance resolution.

Figure 5: Member Services Findings

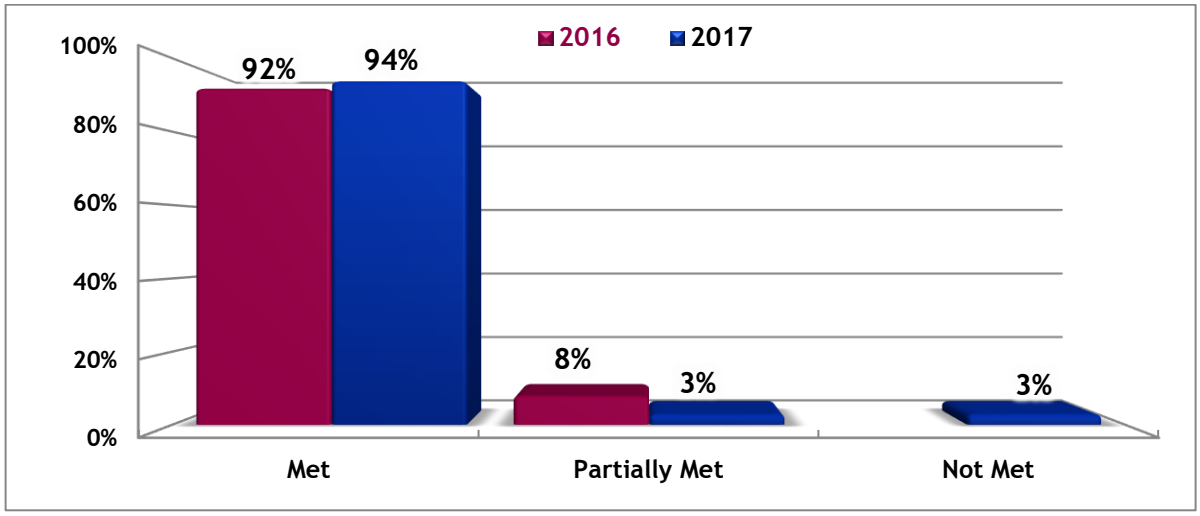


Table 3: Member Services Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Member MCO Program Education	Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Partially Met	Met
	Member program education materials are written in a clear and understandable manner and meet contract requirements	Met	Partially Met
Grievances	Timeliness guidelines for resolution of the grievance as specified in the contract	Partially Met	Met
	The MCO applies the grievance policy and procedure as formulated	Partially Met	Not Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Member Services staff include several Spanish-speaking representatives to assist members whose primary language is Spanish.
- Member Services staff are available on holidays to assist members.
- Select Health's website includes a secure Member Portal and online personal health records to track personal health information such as dates of last doctor visits, tests, etc. A printable *Care Reference Guide* allows members to track a host of information, including names and phone numbers of all their providers and caregivers, allergies, medications, diet and exercise plans, and emergency plans.

Weaknesses

- Page 2 of the *Member Handbook* states that the *Provider Directory* includes a list of participating providers along with their address, phone number, specialty, and whether they are accepting new patients. It does not inform members that alternate languages spoken by providers are also listed in the *Provider Directory*.

- Page 2 of the *Member Handbook* lists a fax number for Member Services, but the fax number is not found in the table on page 34.
- Requirements for member materials found in the *SCDHHS Contract*, *Sections 3.16.1.2* and *3.16.1.3* were not located in submitted policies. Staff stated they believed a policy is in place and would submit the policy to CCME for review. At the time of this report, no policy has been received.
- Response rates for the member satisfaction surveys conducted 2017 showed only a slight increase over the 2016 response rates—from 23% to 24% (Child) and from 20% to 21% (Adult).
- One grievance file reflected an inappropriate resolution that the member was financially liable for an emergency room visit at an out-of-network facility because the provider did not obtain authorization. This is not in compliance with Select Health policy, the Member Handbook, or the *SCDHHS Contract*, *Section 4.2.11.1*. This issue was identified during the previous EQR.
- Policy MMS.100, Member Grievances and Appeals Process references a Culturally & Linguistically Appropriate Services (CLAS) Coordinator position. Onsite discussion revealed the position of CLAS Coordinator no longer exists.

Quality Improvement Plans

- Define the contractual requirements for reading level and font size for member materials and Select Health's processes for ensuring compliance with those requirements in a new or existing policy.
- Ensure members are not held liable for emergency services regardless of whether the provider has a contract with Select Health.

Recommendations

- Revise the *Member Handbook* to include that alternate languages spoken by providers are listed in the *Provider Directory*.
- Include the Member Services fax number on page 34 of the *Member Handbook*.
- Continue working with vendors to increase response rates for the adult and child member satisfaction surveys. Possible ways to increase response rates could include announcing the survey in bulletins and on the website and adding a reminder to call center scripts. Decide upon an internal goal to increase response rates (such as a 2% increase each year).
- Remove the reference to the CLAS Coordinator from Policy MMS.100, Member Grievances and Appeals Process.

D. Quality Improvement

Select Health's *Quality Assessment and Performance Improvement 2017 Program Description* outlines the program in place for measuring and improving the care and services received by members and providers. The Quality Assurance Performance Improvement Committee, Dr. Fred Hill, Regional Chief Medical Officer, and Faleshia Jones, Director of Quality Management, are responsible for planning, designing, implementing and coordinating all quality improvement (QI) activities.

The approval page of the Program Description was blank. This was discussed during the onsite and staff indicated the document is presented to the Quality Assurance Performance Improvement Committee (QAPIC) for review and approval.

Select Health develops a work plan annually to guide and track all QI activities. The 2016 and 2017 work plans were provided with the desk materials. Both included activities to be conducted, objectives for each activity, overall goal, person(s) responsible, and monitoring frequency.

Select Health's *2017 Quality Assessment and Performance Improvement Annual Work Plan and Program Description* include delegation oversight and monitoring. However, the list of delegates on page 37 of the *Program Description* does not include all the delegates. The list only includes the credentialing delegates, whereas the work plan includes utilization and credentialing delegates.

The QAPIC provides oversight for all quality, utilization management and integrated health care management activities. Rebecca Engelman, Market President, serves as chairperson for the QAPIC, and membership includes a variety of network providers and health plan leadership staff. A quorum is defined as 50% of voting members present during the meeting. Committee minutes demonstrated the quorums were met.

Performance Measure Validation

CCME conducted a validation review of the HEDIS performance measures following CMS-developed protocols. This process assesses the application of these measures by the health plan to confirm reported information is valid.

Select Health uses Inovalon, a certified software organization, for calculation of HEDIS rates. Rates were audited by HealthcareData Company. The comparison from the previous to the current year revealed a strong increase in Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) for children ages 1 to 5. The most problematic measures were Statin Therapy for Patients with Cardiovascular Disease (spc) and Follow-Up After Hospitalization for Mental Illness (fuh), which decreased

substantially from last year. A performance improvement project has been established for the follow-up measure.

All relevant HEDIS performance measures are detailed in *Table 4: HEDIS Performance Measure Data*.

Table 4: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	82.13%	86.31%	4.18%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
• BMI Percentile	68.21%	71.53%	3.32%
• Counseling for Nutrition	56.07%	59.03%	2.96%
• Counseling for Physical Activity	52.10%	56.25%	4.15%
Childhood Immunization Status (cis)			
• DTaP	73.07%	75.23%	2.16%
• IPV	86.09%	88.19%	2.10%
• MMR	87.42%	90.05%	2.63%
• HiB	82.78%	84.26%	1.48%
• Hepatitis B	84.55%	85.42%	0.87%
• VZV	87.86%	90.05%	2.19%
• Pneumococcal Conjugate	75.06%	78.94%	3.88%
• Hepatitis A	82.34%	88.66%	6.32%
• Rotavirus	76.16%	78.24%	2.08%
• Influenza	43.93%	42.82%	-1.11%
• Combination #2	66.89%	70.14%	3.25%
• Combination #3	64.46%	68.29%	3.83%
• Combination #4	62.25%	67.59%	5.34%
• Combination #5	58.94%	63.19%	4.25%
• Combination #6	37.53%	38.19%	0.66%
• Combination #7	57.40%	62.50%	5.10%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
• Combination #8	35.98%	38.19%	2.21%
• Combination #9	34.88%	36.34%	1.46%
• Combination #10	33.33%	36.34%	3.01%
Immunizations for Adolescents (ima)			
• Meningococcal	70.50%	74.54%	4.04%
• Tdap/Td	86.95%	88.43%	1.48%
• Combination #1	68.93%	72.69%	3.76%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	23.23%	26.16%	2.93%
Lead Screening in Children (lsc)	66.67%	75.38%	8.71%
Breast Cancer Screening (bcs)	60.77%	61.85%	1.08%
Cervical Cancer Screening (ccs)	63.33%	66.50%	3.17%
Chlamydia Screening in Women (chl)			
• 16-20 Years	48.94%	51.98%	3.04%
• 21-24 Years	58.20%	63.23%	5.03%
• Total	51.39%	55.32%	3.93%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	78.24%	79.30%	1.06%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	33.44%	32.90%	-0.54%
Pharmacotherapy Management of COPD Exacerbation (pce)			
• Systemic Corticosteroid	66.25%	64.55%	-1.70%
• Bronchodilator	80.54%	80.57%	0.03%
Medication Management for People with Asthma (mma)			
• 5-11 Years - Medication Compliance 50%	62.03%	63.66%	1.63%
• 5-11 Years - Medication Compliance 75%	34.88%	37.05%	2.17%
• 12-18 Years - Medication Compliance 50%	54.68%	60.27%	5.59%
• 12-18 Years - Medication Compliance 75%	30.16%	33.94%	3.78%
• 19-50 Years - Medication Compliance 50%	59.13%	59.96%	0.83%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
• 19-50 Years - Medication Compliance 75%	36.30%	37.24%	0.94%
• 51-64 Years - Medication Compliance 50%	68.81%	70.83%	2.02%
• 51-64 Years - Medication Compliance 75%	49.54%	52.78%	3.24%
• Total - Medication Compliance 50%	59.41%	62.33%	2.92%
• Total - Medication Compliance 75%	33.66%	36.35%	2.69%
Asthma Medication Ratio (amr)			
• 5-11 Years	68.66%	69.20%	0.54%
• 12-18 Years	56.92%	61.30%	4.38%
• 19-50 Years	50.27%	53.30%	3.03%
• 51-64 Years	52.03%	54.12%	2.09%
• Total	62.51%	64.50%	1.99%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	48.89%	50.69%	1.80%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	73.17%	78.57%	5.40%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
• Received Statin Therapy - 21-75 years (Male)	75.56%	79.33%	3.77%
• Statin Adherence 80% - 21-75 years (Male)	80.51%	63.38%	-17.13%
• Received Statin Therapy - 40-75 years (Female)	76.16%	75.73%	-0.43%
• Statin Adherence 80% - 40-75 years (Female)	80.49%	62.37%	-18.12%
• Received Statin Therapy - Total	75.84%	77.48%	1.64%
• Statin Adherence 80% - Total	80.50%	62.87%	-17.63%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
• Hemoglobin A1c (HbA1c) Testing	89.93%	92.37%	2.44%
• HbA1c Poor Control (>9.0%)	49.83%	47.93%	-1.90%
• HbA1c Control (<8.0%)	41.49%	41.79%	0.30%
• HbA1c Control (<7.0%)	30.19%	32.08%	1.89%
• Eye Exam (Retinal) Performed	56.25%	56.72%	0.47%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
• Medical Attention for Nephropathy	92.19%	92.21%	0.02%
• Blood Pressure Control (<140/90 mm Hg)	53.99%	52.07%	-1.92%
Statin Therapy for Patients with Diabetes (spd)			
• Received Statin Therapy	59.93%	58.18%	-1.75%
• Statin Adherence 80%	55.09%	53.03%	-2.06%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	70.10%	77.22%	7.12%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
• Effective Acute Phase Treatment	48.43%	49.76%	1.33%
• Effective Continuation Phase Treatment	32.10%	33.74%	1.64%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
• 30-Day Follow-Up	65.55%	43.14%	-22.41%
• 7-Day Follow-Up	42.30%	28.79%	-13.51%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
• 30-Day Follow-Up	NR	60.05%	NA
• 7-Day Follow-Up	NR	44.55%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	76.99%	77.20%	0.21%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	73.66%	66.20%	-7.46%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	80.95%	70.59%	-10.36%
Adherence to Antipsychotic Medications for Individual with Schizophrenia (saa)	70.33%	68.29%	-2.04%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
• 1-5 Years	23.08%	36.11%	13.03%
• 6-11 Years	19.24%	20.66%	1.42%
• 12-17 Years	26.55%	24.74%	-1.81%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
• Total	23.87%	23.56%	-0.31%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
• ACE Inhibitors or ARBs	88.18%	88.23%	0.05%
• Digoxin	48.28%	47.30%	-0.98%
• Diuretics	87.75%	88.03%	0.28%
• Total	87.62%	87.85%	0.23%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.35%	1.66%	-0.69%
Appropriate Treatment for Children with URI (uri)	85.41%	84.29%	-1.12%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	22.77%	22.94%	0.17%
Use of Imaging Studies for Low Back Pain (lbp)	72.81%	76.15%	3.34%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
• 1-5 Years	0.00%	0.00%	0.00%
• 6-11 Years	1.30%	0.23%	-1.07%
• 12-17 Years	1.36%	0.28%	-1.08%
• Total	1.32%	0.25%	-1.07%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
• 20-44 Years	82.58%	80.67%	-1.91%
• 45-64 Years	90.41%	89.81%	-0.60%
• 65+ Years	100.00%	92.31%	-7.69%
• Total	84.61%	82.83%	-1.78%
Children and Adolescents' Access to Primary Care Practitioners (cap)			
• 12-24 Months	97.59%	97.27%	-0.32%
• 25 Months - 6 Years	88.84%	88.29%	-0.55%
• 7-11 Years	91.71%	91.75%	0.04%
• 12-19 Years	89.71%	90.28%	0.57%

MEASURE/DATA ELEMENT	Measure Year 2014	Measure Year 2015	PERCENTAGE POINT DIFFERENCT
Prenatal and Postpartum Care (ppc)			
• Timeliness of Prenatal Care	91.50%	89.94%	-1.56%
• Postpartum Care	75.35%	75.30%	-0.05%
Call Answer Timeliness (cat)	85.27%	NR	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
• 1-5 Years	73.33%	60.00%	-13.33%
• 6-11 Years	60.78%	67.01%	6.23%
• 12-17 Years	57.51%	64.19%	6.68%
• Total	59.35%	65.05%	5.70%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
• <21 Percent	5.67%	5.18%	-0.49%
• 21-40 Percent	3.12%	1.83%	-1.29%
• 41-60 Percent	4.25%	6.71%	2.46%
• 61-80 Percent	8.22%	8.23%	0.01%
• 81+ Percent	78.75%	78.05%	-0.70%
Well-Child Visits in the First 15 Months of Life (w15)			
• 0 Visits	0.72%	1.06%	0.34%
• 1 Visit	2.17%	1.32%	-0.85%
• 2 Visits	1.21%	1.06%	-0.15%
• 3 Visits	4.11%	4.50%	0.39%
• 4 Visits	6.76%	5.03%	-1.73%
• 5 Visits	16.43%	14.29%	-2.14%
• 6+ Visits	68.60%	72.75%	4.15%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	69.48%	72.58%	3.10%
Adolescent Well-Care Visits (awc)	53.20%	58.70%	5.50%

NB: Not a benefit; NR: Not reported; NA: Data not available

Performance Improvement Project Validation

CCME validated PIPs in accordance with CMS protocol titled, *"EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012."* 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

Two projects were validated using the protocol. They included Diabetes Outcomes Measures and Follow-Up After Hospitalization for Mental Health Within 7 and 30 Calendar days After Discharge. *Table 5 Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

TABLE 5: Performance Improvement Project Validation Scores

PROJECT	VALIDATION SCORE PERCENTAGE	2017 VALIDATION SCORE
Diabetes Outcomes Measures: Clinical	96/103= 93%	HIGH CONFIDENCE IN REPORTED RESULTS
Follow-Up After Hospitalization for m-Mental Health Within 7 and 30 Calendar Days After Discharge: Non-Clinical	84/96= 88%	CONFIDENCE IN REPORTED RESULTS

All projects were chosen based on sound data analysis and the rationale was provided. The Diabetes Outcomes Measures PIP has now been revised, and a new PIP with only three outcomes measures has been initiated. The rationale, study questions, and measures are clearly defined. The rates are presented clearly and the barriers and interventions are documented. The personnel that are involved in the data collection and their qualifications are briefly mentioned. Additional information regarding their education, experience, or other qualifications should be added to the report. Also, the statistical test used was documented as HEDIS Hybrid, and that is the data collection methodology, not the actual statistical test. Document whether a z-test or Fisher's test is used when comparing the rates once a re-measurement is completed.

The Follow-Up After Hospitalization for Mental Illness Within 7 and 30 Days After Discharge is a new PIP that also contains only baseline data. The rationale was provided, although the data that are specifically relevant to Select Health regarding follow-up were not included. In the rationale, the rates that demonstrate the need for improvement should be included in the rationale section. As with the other PIP, the staff and qualifications should be documented in more detail, as well as the appropriate statistical test. The following table lists the specific errors by project along with recommendations.

TABLE 6: Performance Improvement Project Errors and Recommendations

Project	Section	Reasoning	Recommendation
DIABETES OUTCOME MEASURES	Were qualified staff and personnel used to collect the data?	Staff working with data is not documented.	The personnel that are involved in the data collection and their qualifications are briefly mentioned. Additional information regarding their education, experience, or other qualifications should be added to the report.
	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented clearly for the rates. The statistical test used was labeled as HEDIS Hybrid Methodology, which is not a statistical test, but the sampling method.	The test used needs to be replaced with the actual test that will be used (such as Fisher's exact or z-test) on pages 10, 11, and 12.
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS WITHIN 7 AND 30 CALENDAR DAYS AFTER DISCHARGE	Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services?	Topic was selected based on data, although the actual data to support the statement "data illustrates a need for focus and improvement efforts" are not provided.	Document the actual rates that illustrate the need for focus in the study rationale section.

Project	Section	Reasoning	Recommendation
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS WITHIN 7 AND 30 CALENDAR DAYS AFTER	Were qualified staff and personnel used to collect the data?	Staff working with data is not documented.	The personnel that are involved in the data collection and their qualifications are briefly mentioned. Additional information regarding their education, experience, or other qualifications should be added to the report.
	Did the MCO/PIHP present numerical PIP results and findings accurately and clearly?	Results are presented clearly for the rates. The statistical test used was labeled as HEDIS Admin Data, which is not a statistical test, but the data collection methodology.	The test used needs to be replaced with the actual test that will be used (such as Fisher's exact or z-test) on pages 7 and 9.

Details of the validation of the performance measures and PIPs may be found in the CCME *EQR Validation Worksheets*, Attachment 3.

Figure 6, Quality Improvement Findings, indicates that 93% of the standards received a "Met" score. The "Partially Met" score was related to the quality improvement projects.

Figure 6: Quality Improvement Findings

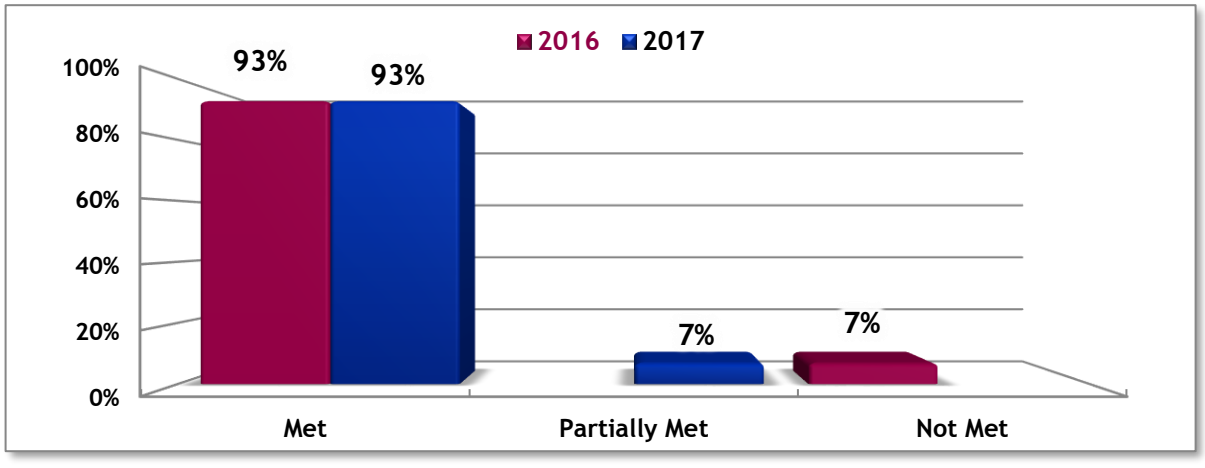


TABLE 7: Quality Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Not Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Analysis of over-and under-utilization was very well done.

Weaknesses

- The approval page of the *QI Program Description* was blank. Also, the list of delegates on page 37 of the *QI Program Description* does not include all the delegates. The list only includes the credentialing delegates, whereas the work plan includes utilization and credentialing delegates.
- Performance improvement project documentation for both projects did not include adequate information regarding staff who work with data and their qualifications.
- The follow-up after hospitalization project did not include rates and evidence to support rationale.

Quality Improvement Plans

- Correct the errors Identified in the performance improvement project documents.

Recommendation

- The approval signature page of the *QI Program Description* should be completed once approval is obtained. Update the delegation list in the Program Description and in the work plan to include all delegation activities.

E. Utilization Management

Select Health's *Integrated Utilization Management Program Description* is specific to the SC Medicaid managed care product. These documents, along with policies and procedures, guide staff in the performance of utilization management (UM) functions.

Member and provider education on UM processes and requirements are provided in various ways, including the *Member Handbook* and *Provider Manual*. However, the *Member Handbook* lacks necessary information regarding who can request an extension of authorization determination timeframes. The *Provider Manual* does not include

information that UM authorization determination timeframes may be extended, under what circumstances, and who may request an extension.

Select Health ensures consistent, uniform clinical criteria application by initial clinical reviewers and second-level reviewers through routine inter-rater reliability (IRR) testing. Testing results are reviewed by the Quality of Clinical Care Committee (QCCC) and QAPIC; included in the annual UM program evaluation; and used to identify training and development needs. As noted in reports of IRR testing results and committee minutes, it is evident that Select Health staff consistently exceed the scoring benchmark of 90%.

During onsite discussion, Select Health staff indicated that to comply with the *SCDHHS Contract*, *Section 8.5.2.*8 requirement for a Preferred Provider Program, a process is in place that eliminates the need for initial notification of pregnancy by certain obstetrical providers. However, the discussion did not provide a clear indication that this process meets the requirement for a Preferred Provider Program based on quality, as required by the *SCDHHS Contract*. Select Health staff indicated documentation to illustrate compliance with this requirement would be submitted to CCME for review; however, at the time of this report, no documentation has been received.

UM approval and denial files confirmed timely determinations, requests for additional clinical information when needed, and use of appropriate criteria.

Select Health has recently implemented a consolidated appeal and grievance policy that addresses processes for receiving and resolving member appeals. Information regarding appeals processes is comprehensively and correctly documented in the policy; however, an incorrect reference to a federal regulation was noted. Issues regarding documentation of appeals processes in the *Provider Manual* included an incomplete definition of an adverse benefit determination and a discrepancy in the appeal filing timeframe. The *Member Handbook* contained an error in the timely filing requirement for requesting continuation of benefits while an appeal is pending and an incorrect reference to a federal regulation.

Two issues were noted in the appeal files reviewed, including resolution letters sent beyond the mandated timeframe and discrepancies in documentation of the date appeals are received. Per onsite discussion, Select Health has already identified and implemented actions to ensure resolution letters are sent within the required timeframe. CCME encouraged staff to identify and eliminate the cause of discrepancies in documentation of the receipt date to eliminate the possibility of untimely appeal acknowledgements and/or resolutions.

Case management and care transitions processes are documented in the *Integrated Health Care Management (IHCM) Program Description* and case management policies. However, a policy addressing the initial health risk screening process was not available

for review. Select Health staff stated Member Services staff conduct initial health risk screenings for new enrollees and described the process during onsite discussion. CCME recommended the initial health risk screening process be documented in policy.

As illustrated in *Figure 7*, 89% of the standards in the Utilization Management section were scored as "Met." All standards scored as "Partially Met" are discussed in detail in the Weaknesses section of this report.

Figure 7: Utilization Management Findings

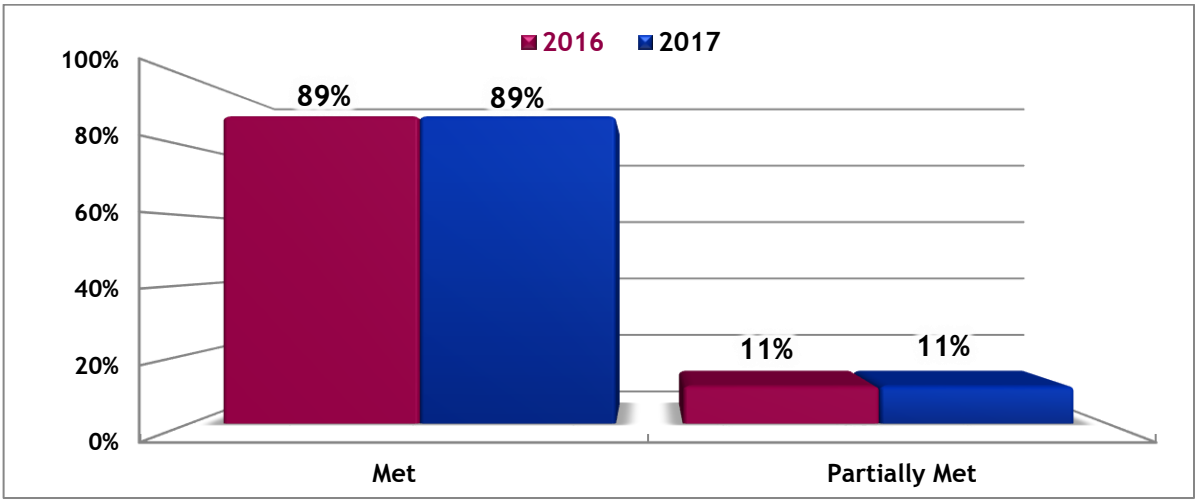


TABLE 8: Utilization Management Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
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 the mechanism to provide for a preferred provider program	Met	Partially Met
Medical Necessity Determinations	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Partially Met	Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Appeals	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 the definitions of an adverse benefit determination and an appeal and who may file an appeal	Met	Partially Met
	Written notice of the appeal resolution as required by the contract	Partially Met	Met
	Other requirements as specified in the contract	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Strengths

- Select Health employs certified InterQual Trainers, and some Bright Start Case Managers are certified Case Managers.
- UM staff and peer reviewers consistently exceed the scoring benchmark for IRR testing.

Weaknesses

- Page 19 of the *Member Hand*book provides UM authorization timeframes and information on extensions, but it does not explain who can request an extension of the authorization timeframes.
- Page 30 of the *Provider Manua*l defines UM authorization timeframes but does not include information on extensions of authorization timeframes or who may request an extension.
- The *SCDHHS Contract, Section 8.5.2.8* requires that a Preferred Provider Program be based on quality, but no documentation was found. Onsite discussion did not clearly indicate a Preferred Provider Program based on quality has been established. Select Health staff indicated documentation to illustrate Select Health's compliance with this requirement would be submitted to CCME for review; however, none was received at the time of this report.
- Page 3 of Policy UM.905S, Emergency Room Services states, "…the treating provider may continue with the care of the member until a network provider is reached or one of the criteria of 42 CFR §422.113(c)(3) is met." The policy does not specify what the

criteria in *42 CFR §422.113(c)(3)* are, and this could limit employee understanding of the requirements.

- For two denial files reviewed, it wasn't clear which Medical Director/designee reviewed the request and issued the denial determination. Also, the adverse benefit determination letter in an initial denial file did not indicate the criteria reviewed to render the denial determination.
- Pages 34-35 and 74 of the *Provider Manual* incompletely define an adverse benefit determination.
- Issues identified with documentation of appeal filing procedures in the *Provider Manual* include:
  - Page 35 incorrectly states an appeal must be filed within 60 calendar days from the date of receipt of denial or action notification.
  - Page 35 incorrectly references a 90-day appeal filing period.
- Page 27 of the *Member Handbook* incorrectly states that the timely filing timeframe for an appeal when requesting continuation of benefits is within 60 calendar days from the date on the adverse benefit determination notice.
- An incorrect reference to a federal regulation is noted on page 8 of Policy MMS.100, Member Grievances and Appeals Process. It states, "The member or the representative files the appeal timely in accordance with 42 CFR section 438.402(c)(1)(ii) and (c)(2)(ii)" The correct reference is *42 CFR § 438.420 (a) (i) and (II)*.
- Issues noted in the review of appeal files included:
  - Two appeal resolution letters were not compliant with the resolution notification timeframe requirement. Select Health staff stated during the onsite interview that this issue has already been identified and corrected.
  - Discrepancies in documentation of the receipt date of three appeals were noted.
- Per onsite discussion, Member Services staff conduct an initial health risk screening for new members within the first 90 days of enrollment. Documentation of this process was not found in policy or in the *IHCM Program Description*.

Quality Improvement Plan

- Revise the *Member Handbook* to explain who can request an extension of authorization timeframes.
- Update the *Provider Manual* to include information on extensions of authorization timeframes, who may request an extension, and circumstances under which Select Health may extend the timeframes.

- Develop and implement a Preferred Provider Program which meets the requirements of the *SCDHHS Contract*, *Section 8.5.2.8*.
- Revise the *Provider Manual* to include the complete definition of an adverse benefit determination as stated in the *SCDHHS Contract*, *Section 9.1 (*b) and *Federal Regulation § 438.400 (b*).
- Revise the *Provider Manual* to reflect the correct timeframe for filing an appeal and correct the reference to the appeal filing period of 90 calendar days. Refer to the *SCDHHS Contract*, *Section 9.1.1.2.2*.
- Correct the timely filing timeframe for continuation of benefits in the bulleted list on page 27 of the *Member Handbook*. Refer to the *SCDHHS Contract*, *Section 9.1.7.1.1*.
- Revise Policy MMS.100, Member Grievances and Appeals Process to include the correct federal regulation reference for timely filing requirements for continuation of benefits.

Recommendations

- Revise policy UM.905S, Emergency Room Services to specify the criteria found in *Federal Regulation §422.113(c)(3)* rather than simply referring to the federal regulation.
- Ensure denial files clearly reflect the reviewer who issues denial determinations and that all adverse benefit determination letters clearly indicate the criteria used in the review and decision-making process.
- Ensure appeal resolution letters are sent in compliance with required timeframes. Ensure the receipt date of appeals is accurately documented throughout the appeal case file to ensure timely acknowledgement.
- Include the process for conducting initial health risk screenings in a policy or in the *IHCM Program Description*.

F. Delegation

Select Health ensures there are written agreements for all entities performing delegated functions. The agreements outline requirements such as responsibilities, reporting requirements, oversight activities, and actions that may be taken for substandard performance.

Policy 277.010, Delegation Oversight defines the processes for pre-delegation assessment of delegate capabilities along with annual oversight of delegate performance.

Policy CR.101.SC, Delegation of Credentialing and Recredentialing Activities defines the processes for delegated credentialing and recredentialing activities. Exhibit A of this

policy details the delegated credentialing agreement and Exhibit B details state-specific credentialing requirements. Several references throughout the policy and exhibits incorrectly refer to language regarding initial onsite reviews that must be conducted for all PCPs.

In addition, Exhibit B contains references to the 2014 *SCDHHS Contract* and the 2014 *Policy and Procedure (P&P)* Guide throughout the document. This outdated document is also used as a SC Medicaid audit tool for the annual reviews.

Select Health has delegation agreements with the following entities:

Table 9: Delegated Entities and Services

Delegated Entities	Delegated Services
Georgia Regents/AU Medical Center Greenville Hospital System Health Network Solutions Mary Black Health Network Medical University of South Carolina Memorial Health Partners Regional Health Plus Roper St. Francis St. Francis Physician Services	Provider credentialing, recredentialing, ongoing monitoring, and decision making
NIA	UM services and provider call center functions
Orange Health Solutions dba Citra Health Solutions	Nurse triage services

Evidence of annual oversight review was received for all delegated entities. For delegated credentialing, Select Health uses an NCQA tool where specific information is detailed for each credentialing/recredentialing file reviewed. They also use a SC Medicaid audit tool specific to *SCDHHS Contract* and *P&P Guide* requirements. As previously mentioned, this audit tool does not reflect current *SCDHHS Contrac*t and *P&P Guid*e language, and it was difficult to determine how SC credentialing requirements were taken into consideration for the file review. The file review was documented on the NCQA tool, which did not contain SC specific requirements. In addition, the audit tool appeared to only address a review of policies and documents.

Select Health documents the delegated entity's overall findings on the *2017 Credentialing Delegation Executive Summar*y sheet. Two delegated entities (Georgia Regents/AU Medical Center and Health Network Solutions) did not indicate that the

ownership disclosure forms had been reviewed. Health Network Solutions' Executive Summary also indicated that a file review had not been completed due to NCQA Credentials Verification Organization (CVO) certification. Onsite discussion confirmed that SC credentialing requirements were reviewed and any issues would have been documented in the summary section of the tool. However, there did not appear to be documentation confirming that SC credentialing criteria was considered.

Overall Select Health is conducting oversight of their delegated entities but there is room for improvement through ensuring the oversight tools reflect current requirements and that file review documentation clearly shows *SCDHHS Contract* and *P&P Guide* requirements are being taken in to consideration.

As noted in *Figure 8, Delegation Findings*, and *Table 10, Delegation Comparative Data*, both standards in the Delegation section received "Partially Met" scores.

Figure 8: Delegation Findings

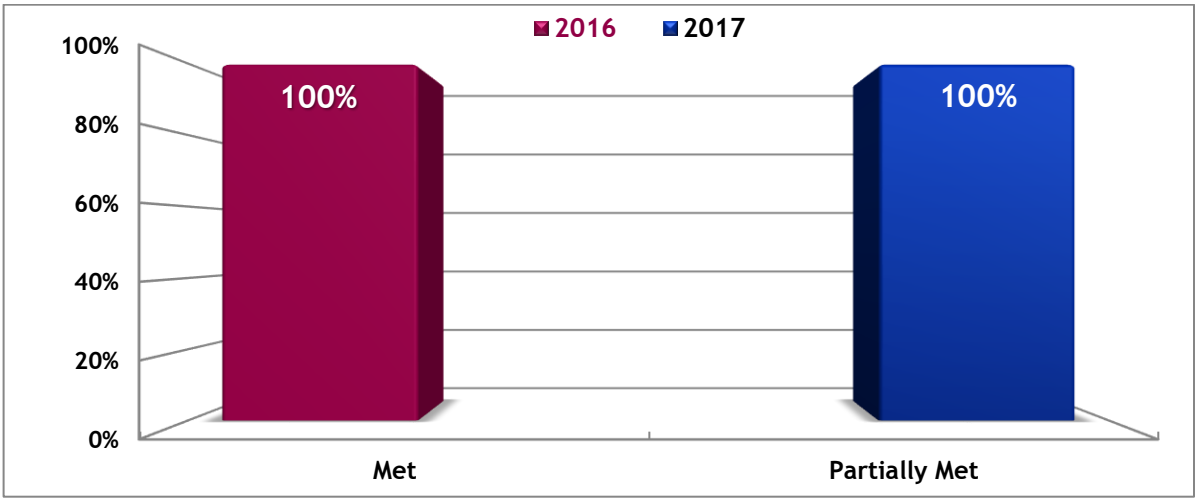


TABLE 10: Delegation Comparative Data

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Delegation	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	Partially Met

SECTION	STANDARD	2016 REVIEW	2017 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to insure 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

The standards reflected in the table are only the standards that showed a change in score from 2016 to 2017.

Weaknesses

- Policy CR.101.SC, Delegation of Credentialing and attached exhibits contain outdated language regarding initial onsite reviews that must be conducted for all PCPs.
- Policy CR.101.SC, Exhibit B contains references to the 2014 *SCDHHS Contract* and the 2014 *P&P Guide* throughout the document. This outdated document is also used as a SC Medicaid audit tool for the annual oversight reviews.
- The delegate file review was documented on the NCQA tool and comments in the SC Medicaid audit tool appeared to only address a review of policies and documents. It was difficult to determine how SC credentialing requirements were taken into consideration for the file review.
- A review of the *2017 Credentialing Delegation Executive Summary* sheets for the delegated entities revealed the following:
  - Two delegated entities (Georgia Regents/AU Medical Center and Health Network Solutions) did not indicate that the ownership disclosure forms had been reviewed.
  - Health Network Solutions' Executive Summary indicated that a file review had not been completed due to NCQA CVO certification. Onsite discussion confirmed that SC credentialing requirements were reviewed and any issues would have been documented in the summary section of the tool. However, there did not appear to be documentation confirming SC credentialing criteria were considered.

Quality Improvement Plans

- Update Policy CR.101.SC and exhibits to remove the outdated language regarding initial onsite reviews for all PCPs.
- Update Policy CR.101.SC, Exhibit B to remove outdated language and references to the 2014 *SCDHHS Contract* and the 2014 *P&P Guide*. This document should reflect current *SCDHHS Contract* and *P&P Guide* language.
- For entities where credentialing has been delegated, ensure that the credentialing/ recredentialing file review tool reflects SC credentialing/recredentialing

requirements. Ensure ownership disclosure forms are reviewed and all entities have a file review to assess compliance to SC credentialing/recredentialing guidelines.

G. State Mandated Services

Select Health provides all core benefits required by the *SCDHHS Contract*.

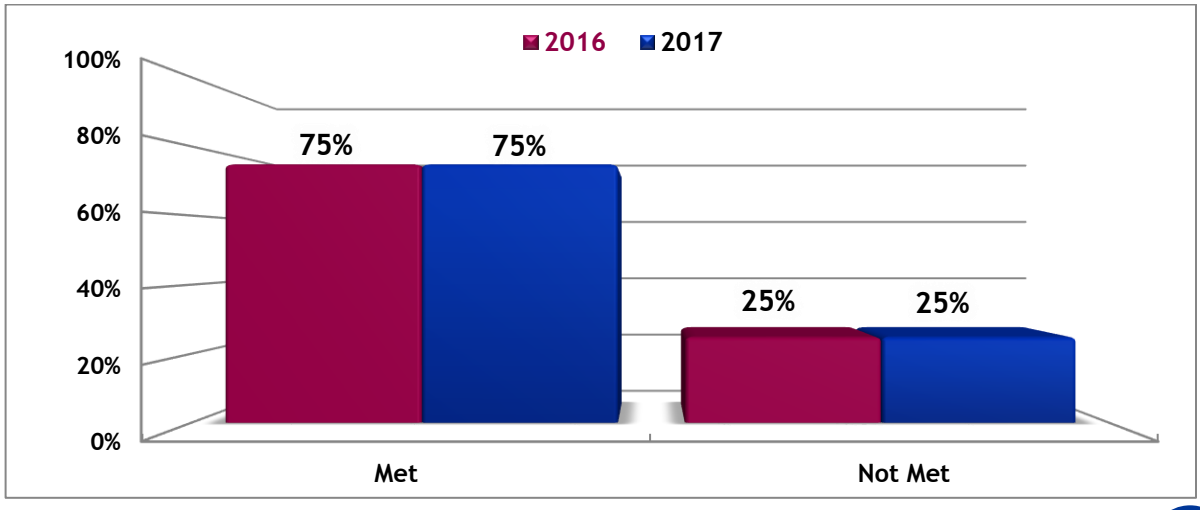
To monitor and track provider compliance with provision of required immunizations and EPSDT services, Select Health conducts annual medical record reviews in conjunction with the annual HEDIS survey. Medical records are assessed for documentation of the immunization record for children and adolescents (18 years and younger) and documentation of preventative screening and services in accordance with Select Health practice guidelines.

Processes are in place to notify and remind providers of needed EPSDT services, including providing PCPs with quarterly lists of members who are due for EPSDT visits, immunizations, and lead screenings. Two provider portals (Navinet and Treo Solutions) allow providers to view members' care gaps. In addition, provider account executives review care gap lists with PCPs during quarterly, face to face meetings.

One deficiency identified in Select Health's grievance resolution process during the previous EQR has not been corrected. This deficiency is due to a member being informed they are financially liable for emergency services provided at a non-participating emergency room. The same issue was identified during the EQR conducted in 2016.

As noted in the chart below, Select Health received a score of "Met" for 75% of the standards in the State Mandated Services section. The score of "Not Met" is related to the uncorrected deficiency from the previous EQR.

Figure 9: State Mandated Services



Weaknesses

- A deficiency identified during the previous EQR in Select Health's grievance process was not corrected.

Quality Improvement Plans

- Ensure all deficiencies identified during the EQR are corrected and the corrections are implemented

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Tabular Spreadsheet

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

September 25, 2017

Ms. Rebecca Engelman
Market President
Select Health of South Carolina, Inc.
4390 Belle Oaks Drive, Suite 400
North Charleston, South Carolina 29405

Dear Ms. Engelman:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2017 External Quality Review (EQR) of Select Health of South Carolina is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **November 9th and 10th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **October9, 2017.**

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

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2017

MATERIALS REQUESTED FOR DESK REVIEW

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

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies.

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

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

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

Excel Spreadsheet Format

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

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

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

8. A copy of the current Compliance plan and organization chart for the compliance department.

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

10. The Quality Improvement work plans for 2016, and 2017.

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

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

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

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

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services.

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

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

18. A complete list of all members enrolled in the case management program from March 2017 through August 2017. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

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

21. A report of findings from the most recent member and provider satisfaction survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

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

23. A copy of the Grievance, Complaint and Appeal logs for the months of September 2016 through September 2017.

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

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

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

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

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

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

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

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

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used and a copy of any tools used.

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

36. Provide electronic copies of the following files:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of September 2016 through September 2017. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of September 2016 through September 2017, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

Note: Appeals, Grievances, and Care Coordination/Case Management files will be selected from the logs received with the desk materials. A request will then be sent to the plan to send electronic copies of the files to CCME.

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2017

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were copied.
2. Compliance Committee minutes from meeting on 6/21/17, if held.
3. A copy of the actual Notice of Privacy Practice document provided to members in their member packet.
4. Credentialing Committee Meeting Minutes and attendee roster for the November 20, 2016 meeting.
5. The following credentialing/recredentialing files were missing information or need explanation:
    a. CRED: Callie Carroll Meeks, MD, OBGYN – Provider did not appear to be board certified and did not see verification of graduation/residency in the file; 5-year work history was not in the file; Answered "Yes" to question 19 on page 17 of the CAQH application and provider explanation was not in the file; and a copy of the State Excluded Provider's Report was not in the file.
    b. CRED: Malcolm Gottlich, MD, Orthopedic Surgery – File did not contain proof of the NPDB query.
    c. CRED: Justin H. Atwood, MD, Pulmonology – The CAQH application only shows work history from 8/17 – present and the checklist refers back to the CAQH application for 5-year proof of work history. No additional information is in the file to establish 5-year work history.
    d. RECRED: Leslie Caughman, LPC, Behavioral health – CAQH application indicates "Yes" to lab, but CLIA is not in the file.

6. Copy of the most recent Network Cultural Assessment mentioned in the 2016 QAPI Evaluation.
7. Copy of the 2017 Geographic Access and Provider to Member Ratio Reports for Specialists. We received a report called Specialty Provider GeoAccess and Ratio Report dated 7/14/16. Please provide specialists results for 2017.
8. A copy of the most recent accessibility report that measures provider appointment availability. We received the accessibility report for after-hours care.

C. Attachment 3: EQR Validation Worksheets

- Performance Measure Validation
- Performance Improvement Project Validation
- Member Satisfaction Survey Validation – CAHPS Adult
- Member Satisfaction Survey Validation – CAHPS Child

CCME EQR PM Validation Worksheet

Plan Name:	**Select Health**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2016**
Review Performed:	**11/2017**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS® TECHNICAL SPECIFICATIONS

GENERAL MEASURE ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
G1. Documentation	Appropriate and complete measurement plans and programming specifications exist that include data sources, programming logic, and computer source codes.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight™ from Inovalon. This was verified and meets all review requirements.

DENOMINATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
D1. Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.
D2. Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1. Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2. Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.
N3. Numerator– Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	This was verified and meets all review requirements.
N4. Numerator– Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.
N5. Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.
S2. Sampling	Sample treated all measures independently.	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Plan NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Plan uses NCQA-certified software Quality Spectrum Insight from Inovalon. This was verified and meets all review requirements.
R2. Reporting	Was the measure reported according to State specifications?	**NA**	NA

VALIDATION SUMMARY

Element	Standard Weight	Validation Result	Score
G1	10	MET	10
D1	10	MET	10
D2	5	MET	5
N1	10	MET	10
N2	5	MET	5
N3	5	NA	NA
N4	5	MET	5
N5	5	MET	5
S1	5	MET	5
S2	5	MET	5
S3	5	MET	5
R1	10	MET	10
R2	5	NA	NA

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Select Health**
Name of PIP:	**DIABETES OUTCOME MEASURES**
Reporting Year:	**2016-2017**
Review Performed:	**10/2017**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Topic was selected based on research and analysis of enrollee care needs as stated on page 1.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study questions were found in the project documentation in the analysis section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are Hba1c >9, hba1c<8, and BP control <140/90.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in processes of care and health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire relevant population included.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	HEDIS Hybrid methodology was utilized.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	HEDIS Hybrid methodology was utilized.

Component / Standard (Total Points)	Score	Comments
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS Hybrid methodology was utilized.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was conducted according to Hybrid methods
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**PARTIALLY MET**	The personnel that are involved in the data collection and their qualifications are briefly mentioned. Additional information regarding their education, experience, or other qualifications should be added to the report. ***Recommendation**: Include staff and qualifications of staff that are pulling and collecting data.*
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers that were addressed by interventions were noted.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Results are presented clearly for the rates. The statistical test used was labeled as HEDIS Hybrid Methodology, which is not a statistical test, but the sampling method. ***Recommendation:** The test used needs to be replaced with the actual test that will be used (such as Fisher's exact or z-test) on pages 10, 11, and 12.*

Component / Standard (Total Points)	Score	Comments
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline measurements only for the new outcomes are presented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation included both qualitative and quantitative discussion of results.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	This is a new PIP with baseline data only; therefore, improvements are unable to be evaluated as of now.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Validity cannot be evaluated, as improvement requires at least two points of measurement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical significance cannot be evaluated, as improvement requires at least two points of measurement.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	This is a new PIP with baseline data only; therefore, improvements are unable to be evaluated as of now.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	PIP reported third-party validated HEDIS measures.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	5		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	3
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	5
Step 4				8.3	NA	NA
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	5	5		9.2	NA	NA
5.2	10	10		9.3	NA	NA
5.3	5	5		9.4	NA	NA
Step 6				Step 10		
6.1	5	5		10.1	NA	NA
6.2	1	1		Verify	NA	NA
6.3	1	1				

Project Score	96
Project Possible Score	103
Validation Findings	93%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

Plan Name:	**Select Health**
Name of PIP:	**FOLLOW UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS WITHIN 7 AND 30 CALENDAR DAYS AFTER DISCHARGE**
Reporting Year:	2016-2017
Review Performed:	10/2017

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**NOT MET**	Topic was selected based on data, although the actual data to support the statement "data illustrates a need for focus and improvement efforts" are not provided. ***Recommendation:*** *Document the actual data that illustrate the need for focus in the Study Rationale section.*
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	A broad spectrum of enrollee care and services are addressed.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All relevant populations are included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Study questions were found in the project documentation in the analysis section.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are clearly defined.
3.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators measure changes in processes of care.

Component / Standard (Total Points)	Score	Comments
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Study population was clearly defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Entire relevant population included.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**NA**	Sampling is not used.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**NA**	Sampling is not used.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**NA**	Sampling is not used.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Study design clearly specifies data collection cycle as per HEDIS specifications.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection was conducted according to HEDIS specifications
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**PARTIALLY MET**	The personnel that are involved in the data collection and their qualifications are briefly mentioned. Additional information regarding their education, experience, or other qualifications should be added to the report. ***Recommendation****: Include staff and qualifications of staff that are pulling and collecting data.*

Component / Standard (Total Points)	Score	Comments
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers that were addressed by interventions were noted.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analysis was conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**PARTIALLY MET**	Results are presented clearly for the rates. The statistical test used was labeled as HEDIS Admin Data, which is not a statistical test, but the data collection methodology. ***Recommendation:*** *The test cited needs to be replaced with the actual test that will be used (such as Fisher's exact or z-test) on pages 7 and 9.*
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline measurements only for the new outcomes are presented.
8.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Project documentation included both qualitative and quantitative discussion of results.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NA**	This is a new PIP with baseline data only; therefore, improvements are unable to be evaluated as of now.
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Validity cannot be evaluated, as improvement requires at least two time points of measurement.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical significance cannot be evaluated, as improvement requires at least two time points of measurement.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	This is a new PIP with baseline data only; therefore, improvements are unable to be evaluated as of now.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	PIP reported third-party validated HEDIS measures.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score		Steps	Possible Score	Score
Step 1				Step 6		
1.1	5	0		6.4	5	5
1.2	1	1		6.5	1	1
1.3	1	1		6.6	5	3
Step 2				Step 7		
2.1	10	10		7.1	10	10
Step 3				Step 8		
3.1	10	10		8.1	5	5
3.2	1	1		8.2	10	5
Step 4				8.3	NA	NA
4.1	5	5		8.4	1	1
4.2	1	1		Step 9		
Step 5				9.1	5	5
5.1	5	5		9.2	NA	NA
5.2	10	10		9.3	NA	NA
5.3	5	5		9.4	NA	NA
Step 6				Step 10		
6.1	NA	NA		10.1	NA	NA
6.2	NA	NA		Verify	NA	NA
6.3	NA	NA				

Project Score	84
Project Possible Score	96
Validation Findings	88%

AUDIT DESIGNATION
CONFIDENCE IN REPORTED RESULTS

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

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2017
Review Performed	11/2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2017 Adult Medicaid Summary Report-Select Health*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2017 Adult Medicaid Summary Report-Select Health*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. Select Health had a sample size of 1,664 eligible members. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2017 Adult Medicaid Summary Report-Select Health*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 21% (n=357 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was not met, and the response rate was below the NCQA target rate. Documentation: *2017 Adult Medicaid Summary Report-Select Health* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2017 Adult Medicaid Summary Report-Select Health*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2017 Adult Medicaid Summary Report-Select Health*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2017 Adult Medicaid Summary Report-Select Health*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS-certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - Morpace as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 21%. The target response rate according to NCQA is 40.0%. Caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Overall, Select Health's adult members did improve their overall satisfaction levels for most of the composite and rating measures compared to last year. Select Health members gave the highest ratings of satisfaction to the composite measures for Customer Service and the lowest rating for Getting Care Quickly. In the overall rating measures, the members gave the highest rating for Health Plan while the lowest rating was for Health Care. Documentation: *CAHPS Adult 2017 Analysis*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Access and quality of care analysis was conducted. Documentation: *CAHPS Adult 2017 Analysis*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *2017 Adult Medicaid Summary Report- Select Health*

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2017
Review Performed	11/2017

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted, since the lack of information is relevant to the assessment of that activity. (V2 updated based on September 2012 version of EQR protocol 5)

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

Survey Element		Element Met / Not Met	Comments And Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	The statement of purpose is documented. Documentation: *2017 Child Medicaid Summary Report-Select Health*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are clearly documented. Documentation: *2017 Child Medicaid Summary Report-Select Health*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *2017 Child Medicaid Summary Report-Select Health*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey is documented. Documentation: *2017 Child Medicaid Summary Report-Select Health*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses are documented. Documentation: *2017 Child Medicaid Summary Report-Select Health*

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments And Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Definition of the study population was clearly defined. Documentation: *2017 Child Medicaid Summary Report-Select Health*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *2017 Child Medicaid Summary Report-Select Health*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *2017 Child Medicaid Summary Report-Select Health*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. Select Health had a sample size of 2,052 eligible members. Documentation: *2017 Child Medicaid Summary Report-Select Health*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *2017 Child Medicaid Summary Report-Select Health*

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments And Documentation
4.1	Review the specifications for calculating raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *2017 Child Medicaid Summary Report-Select Health*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**NOT MET**	The overall response rate was 24% (n=495 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, although the response rate was below the NCQA target rate. Documentation: *2017 Child Medicaid Summary Report-Select Health* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents.*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments And Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A quality assurance plan was in place. Documentation: *2017 Child Medicaid Summary Report-Select Health*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *2017 Child Medicaid Summary Report-Select Health*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *2017 Child Medicaid Summary Report-Select Health*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *2017 Child Medicaid Summary Report-Select Health*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *2017 Child Medicaid Summary Report-Select Health*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *2017 Child Medicaid Summary Report-Select Health*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

	Results Elements	Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	-The use of a CAHPS-certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. - Morpace as a vendor provides a full report of process and results that meets the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 24%. The target response rate according to NCQA is 40.0%. Caution should be used when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Overall, Select Health's child members did not improve their overall satisfaction levels of the composite measures compared to last year. The results further indicated that Select Health child members slightly gave their highest proportion of satisfaction to the overall rating measures for Specialist and Health Plan compared to previous year. Documentation: *CAHPS Child 2017 Analysis*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Access and quality of care analysis was conducted. Documentation: *CAHPS Child 2017 Analysis*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation : *2017 Child Medicaid Summary Report- Select Health*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Select Health**
Collection Date:	**2017**

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy 168.001, Policy and Procedure Program Management and Format Guidelines establishes a uniform method of writing, issuing, and reviewing Select Health policies and procedures. Department heads and all identified stakeholders perform initial review with follow-up review and approval by the policy and procedure team on annual basis.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						Staffing and leadership personnel levels appear adequate to ensure Select Health can provide all health care products and services required by the *SCDHHS Contract*. Changes are communicated to leadership and all staff are tracked for compliance to reading new or changed information in policies.
1.1 *Administrator (CEO, COO, Executive Director);	X					Rebecca Engelman is Market President. She oversees the plan's day-to-day business activities.
1.2 Chief Financial Officer (CFO);	X					Sean Popson, Director of Finance, reports to Sharon Duncan, CPA, Vice President, Finance at AmeriHealth Caritas.
1.3 * Contract Account Manager;	X					James King is Contract Account Manager.
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Kathy Turnbull is Director of Claims. Jasmine Garcia is Manager. Neil Canavan is Vice President-Health Services Payment at AmeriHealth Caritas. Other staff include a claims examiner and an analyst. Michele Bowerman is the Manager of Information Services (IS) Encounters.
1.4.2 Network Management Claims/ Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Melissa McDaniel, Manager of Utilization Management, reports to the Kathy McElheney, Regional UM Director, AmeriHealth Caritas, Region 1.
1.5.1 Pharmacy Director,	X					Jay Messeroff is Regional Pharmacy Director and Kelly Martin is Regional Clinical Pharmacist; both are licensed pharmacists in SC.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.2 Utilization Review Staff,	X					The UM review staff are supervised by a registered nurse and/or licensed clinician. As members of the UM Call Center, they receive calls from providers and answer questions about access to medical services/ care for members. The Clinical Care Review (CCR)/Licensed Clinical Reviewers are under the direction of licensed physicians and they review requests from providers and apply approved criteria. They can approve the provider's request if criteria are met. If criteria are not met, the CCR will forward the information to the Medical Director for a medical necessity determination. CCRs are also responsible for discharge planning, identifying quality of care concerns and referring members to rapid response or care management, when needed.
1.5.3 *Case Management Staff,	X					All case managers are located in South Carolina.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Faleshia Jones is the Director of Quality Management.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Staff includes data analysts, team leads and performance specialists.
1.7 *Provider Services Manager;	X					Phillip Fairchild is the Director of Provider Network Operations and Peggy Vickery is the Director of Provider Network Management.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Kevin Vaughan is the Director of Member Services. Toni Parnell is the Manager of Member Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Greg Barabell is the Market CMO. He is board certified in pediatrics.
1.10 *Compliance Officer;	X					Deonys de Cardenas is the Director of Compliance and Dustin Brockshire is the Compliance Manager.
1.10.1 Program Integrity Coordinator;	X					Elizabeth Saragusa is the Manager-Special Investigations Unit at AmeriHealth Caritas and also the Program Integrity Coordinator. The SIU is responsible for detecting and preventing FWA throughout the claims payment processes for all AmeriHealth Caritas lines of business, including Select Health. The SIU has dedicated staff that supports Select Health.
1.10.2 Compliance /Program Integrity Staff;	X					Staff includes the Compliance Officer and Compliance Specialist locally, and numerous other staff and subcontractors with numerous functions supporting program integrity.
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist	X					Dr. Roger Beardmore is the Medical Director for Behavioral Health. He is a SC-licensed psychologist and has been approved by SCDHHS.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions.	X					Policy HR 116.103, Employee Credentialing defines the procedures to verify and ensure that associates whose positions require particular licenses and/or certifications meet the requirements detailed in their job descriptions at the time of hire and during employment at Select Health.
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Select Health reports that 99.9% of all clean claims are paid in 30 days and 99.9% of all claims are paid in 90 days. These times meet and exceed the standards of the *SCDHHS Contract*.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Select Health receives files electronically daily and monthly. These data are checked for accuracy by monitoring file contents and comparing that data with historical data trends. Data that deviates from the expected trend are investigated with the submitting party. Before electronically transmitting files to the state, the data are reviewed to ensure HIPAA compliance. The supporting documentation provided within the ISCA collection demonstrates that Select Health can adequately conduct electronic transactions in a method that the meets or exceeds the requirements of the *SCDHHS Contract*.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Select Health loads South Carolina enrollment into an eligibility and claims processing system. Errors or discrepancies in the enrollment data are identified in the claims processing system. If an error or discrepancy is detected, Select Health has policies and procedures in place to report the error to members of their enrollment department. A single unique member ID number is generated in the system to identify Medicaid members across multiple systems. Duplicate member data entering systems are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						prevented by systems that manage Medicaid members. Should a situation arise where duplicate member data does exist, Select Health has tools and processes in place to resolve the data duplication and communicate the issue to the SCDHHS.
4. The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Select Health's ISCA documentation indicates that the necessary systems and processes are in place to adequately collect, report, and process data required by the *SCDHHS Contract*.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					According to the documentation provided, Select Health assesses the security of the systems used to fulfill the *SCDHHS Contract*. The assessment results summarized within the ISCA documents indicate a laudable overall secure operating environment and focus on data security. Examples of this focus are: regular hacking exercises, HIPAA security audits every two years, and a risk assessment completed in the summer of 2017.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					The Select Health ISCA documentation indicates adequate policies and procedures are in place to secure data as required by the *SCDHHS Contract*. The appropriate measures are in place to log and monitor data security. Physical and network security best practices are used to secure Medicaid data.
7. The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented.	X					The documents provided by Select Health state that they have implemented disaster recovery as well as business continuity plans for the systems that service the *SCDHHS Contract*. It also shows that plans are well documented and incorporate a complete recovery strategy for disaster recovery and business continuity. Annual disaster recovery and business continuity tests and the most recent results indicate that the exercises were completed successfully.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I D. Compliance/Program Integrity						
1. The MCO has written policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse.	X					Select Health's compliance program is comprehensive and numerous policies address program integrity, including fraud, waste and abuse (FWA).
2. Written policies, training plans, and/or the Compliance Plan includes employee and subcontractor training.	X					Select Health provides extensive new employee and annual training on compliance; FWA; disclosure of Protected Health Information (PHI); privacy, etc. Each employee receives the *Code of Conduct and Ethics* handbook and providers receive regional trainings and ad hoc trainings as appropriate.
3. The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities.	X					The Select Health Compliance Committee assists the Director of Compliance with the implementation and oversight of the Select Health Compliance and Privacy Program. The Director of Compliance chairs the committee, which meets at least quarterly or at a minimum of three times a year. The committee consists of personnel from various functional areas. A quorum is established upon attendance of at least 50 percent of voting members or at least eight voting members.
4. The MCO has policies and procedures in place that define the processes used to conduct post payment audits and recovery activities for fraud, waste, and abuse activities.	X					Select Health submitted examples and lists of the claim and investigative processes used to detect fraud, waste, and abuse. The *Program Integrity Plan* defines the processes used to conduct these audits.
5. The MCO has policies and procedures that define how investigations of all reported incidents are conducted.	X					Per the *Program Integrity Plan*, the SIU team proactively identifies potential incidents of suspected fraud and abuse as part of its program for ongoing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitoring and auditing. Audits include claims data reviews to detect inconsistencies or abnormal behavior for billing and prior authorizations; pre-and post-payment reviews; and random, periodic sampling of claims. External vendors conduct some of these functions, which include data mining and recovery. Several policies were received: •Policy 168.104, Compliance Investigations, Inquiries, and Non-Retaliation Policy •Policy 168.117, Corrective Action Plans, Remedial Action Plans.
I E. Confidentiality						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy 168.101, Confidentiality details Select Health's commitment to confidentiality by requiring confidentiality agreements from associates, subcontractors, providers, and committee members. These agreements are signed on the first day of employment and annually thereafter. The policy addresses how Select Health protects PHI in all forms. Policies define how PHI may be obtained or released in different circumstances. The *Notice of Privacy Practices* is mailed to members with new enrollee materials.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
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.		X				*Credentialing Program 2017* and Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing define the procedures for provider credentialing and recredentialing. Additional policies also address processes related to credentialing. The following issues were identified: •The Exclusion and Termination for Cause List is not mentioned in the credentialing program description, *Provider Manual* or any of the policies. *(*Reference *SCDHHS Policy and Procedure (P&P) Guide, Section 11.1.)* Onsite discussion confirmed the list is being checked as required. •Policy CR.112.SC, Credentialing/Recredentialing Provider Denial, Termination or Reconsideration Appeal Process references policy QM 154.300 and should reference QM 154.010. •Policy CR.112.SC defines that the Credentialing Committee reviews reconsiderations and if a provider appeals, then the Medical Director (who chairs the Credentialing Committee) will select members for a professional review committee and identify a chair person for the appeal hearing. However, page 12 of the *Provider Manual* states the QAPIC Committee reviews provider appeals. Onsite discussion confirmed the *Provider Manual* is incorrect. *Quality Improvement Plan: Update the credentialing program description, applicable policies/Provider Manual to reflect that the Exclusion and Termination for Cause List is being reviewed at initial*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						credentialing, recredentialing, and monthly. Remove the incorrect policy reference in Policy CR.112.SC, and correct the discrepancy between Policy CR.112.SC and the Provider Manual regarding which committee reviews provider appeals.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.		X				Dr. Greg Barabell, Market CMO chairs the Credentialing Committee, and current voting members include the Regional CMO, five Select Health Medical Directors, and eight network providers with the specialties of pediatrics, family practice, OB/GYN, and orthopedic surgery. The committee chair votes only in place of a tie, and a quorum is met with over 50% of the voting members in attendance. A review of committee meeting minutes shows the quorum was not met in the following four meetings: October 26, 2016, November 30, 2016, May 31, 2017, and June 28, 2017. The Credentialing Committee minutes are very detailed; however, they do not indicate if a voting quorum has been established. *Quality Improvement Plan: Ensure a quorum has been established at each Credentialing Committee meeting.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed below.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement 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 convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;		X				Credentialing files reviewed did not contain evidence the Exclusion and Termination for Cause List had been queried; however, onsite discussion confirmed this list is queried at credentialing. All credentialing files reviewed did contain evidence of query of the SC excluded providers list. *Quality Improvement Plan: Credentialing files should contain evidence of query of the Exclusion and Termination for Cause List.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);			X			The credentialing file review did not include evidence the SSDMF had been searched. Onsite discussion confirmed that Select Health is currently implementing a process to query the SSDMF. *Quality Improvement Plan: Ensure credentialing files include proof of query of the SSDMF.*
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.16 Ownership Disclosure form.	X					Ownership disclosure forms are collected during credentialing and recredentialing. Annually, Select Health contacts the disclosing entity to verify that the information submitted on the SCDHHS 1514 is still correct. If any information has changed, a new form is collected.
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing files were organized and for the most part contained appropriate documentation. Any issues are discussed below.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list;		X				Recredentialing files reviewed did not contain evidence the Exclusion and Termination for Cause List had been queried; however, onsite discussion confirmed this list is queried at credentialing. All recredentialing files reviewed did contain evidence of query of the SC excluded providers list. *Quality Improvement Plan: Recredentialing files should contain evidence of query of the Exclusion and Termination for Cause List.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);			X			The recredentialing file review did not include evidence the SSDMF had been searched. Onsite discussion confirmed that Select Health is currently implementing a process to query the SSDMF. *Quality Improvement Plan: Ensure recredentialing files include proof of query of the SSDMF.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					Examples of provider performance reports were received in the desk materials. The reports are produced on a quarterly basis and include selected HEDIS quality performance measures.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.		X				Policy QI 154.010, Review of Potential Quality of Care Concerns defines the process for investigating, monitoring, reporting and trending of potential quality of care concerns that are identified through internal and external sources. Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality describes the purpose and process for conducting sanctioning activities and compliance with reporting requirements. This policy contains an incorrect policy reference. It refers to policy QI 154-300, Review of Potential Quality of Care Concerns, which is no longer an active policy. *Quality Improvement Plan: Update Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality to remove the QI 154-300 policy reference.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				Policy CR.103.SC, Organizational Provider Credentialing & Recertification Process and the *Credentialing Program 2017* define the process of credentialing/recredentialing organizational providers. The following discrepancies and issues were noted: •Page 19 of *Credentialing Program 2017*, Section 2c. has a paragraph related to the DHHS Program Integrity unit and the Medicaid Fraud Control unit that is not mentioned on page 2 of Policy CR.103.SC, Section 1. •Page 24 of *Credentialing Program 2017*, #20, has updated information that is not listed on page 6 of Policy CR.103.SC regarding the DHHS Program Integrity unit and the Medicaid Fraud Control Unit. In addition, it states that no appeal process is afforded to providers during initial credentialing in #22, and this is not listed in Policy CR.103.SC. •Page 25 of *Credentialing Program 2017*, #7, has updated information that is not listed on page 7 of Policy CR.103.SC, #6a, regarding the DHHS Program Integrity Unit and the Medicaid Fraud Control Unit. •Pages 3 and 7 of Policy CR.103.SC discuss required queries but do not specifically mention the *SC* Excluded Provider List or the Exclusion and Termination for Cause List. *Quality Improvement Plan: Update Credentialing Program 2017 and/or Policy CR.103.SC to reflect consistent information regarding organizational providers. Ensure Policy CR.103.SC specifies the required queries instead of using general terms.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				Policy CR.104.SC, Ongoing Monitoring-Licensure and Medicare/Medicaid Sanctions defines the process of monitoring of licensure sanctions, Medicare/Medicaid

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sanctions, data bank activity, and potential quality of service issues on a monthly basis. The policy does not address the monitoring of the Exclusion and Termination for Cause List that is required in the *SCDHHS P&P Guide, Section 11.1.* Also, the *Credentialing Program 2017* has a section for ongoing monitoring on page 28 that mentions some required queries but does not mention the SC State Excluded Provider List or the Exclusion and Termination for Cause List. *Quality Improvement Plan: Update Policy CR.104.SC, Ongoing Monitoring-Licensure and Medicare/Medicaid Sanctions to address the process of monitoring the Exclusion and Termination for Cause List on a monthly basis. Also, update the Credentialing Program 2017 description to address the monitoring of the SC State Excluded Provider List and the Exclusion and Termination for Cause List in the Ongoing Monitoring section.*
II B. Adequacy of the Provider Network						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					GEOAccess reports were received for 2017 measuring time and distance as required by the *SCDHHS Contract*. The reports show PCPs (family practice/general practice, pediatric, and internal medicine) measured as 1 within 30 miles/1 within 45 minutes with results showing 100% compliance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy NM 159.206, Availability of Practitioners establishes the geographic standards for PCPs and OB/GYNs as one within 30 miles for rural. Pediatrics, family and general practice are two within 20 miles for urban/suburban. Internal medicine is one within 30 miles and OB/GYNs are one within 20 miles for urban/suburban. These geographic standards are monitored on an annual basis through GEOAccess reports and results are reported to the QAPIC Committee. Select Health also submits a complete listing of its provider network twice a year to the State as required. The memorandum of results dated August 31, 2017, for primary care and behavioral health providers showed the goal of 95% compliance as being met. In addition, Select Health also measures the total network ratio of providers to members for each type of physician providing primary care, and the goals were met for all PCP types.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy NM 159.206, Availability of Practitioners establishes the geographic standards for specialists as one within 30 miles for urban and one within 50 miles for rural. These geographic standards are monitored on an annual basis through GEOAccess reports, and results are reported to the QAPIC Committee. Policy NM 159.304, Behavioral Health Provider Availability establishes the geographic standards for behavioral health required providers to include psychologists, psychiatrists, licensed professional counselors, and rehabilitative behavioral health providers. The standard is one within 50 miles.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2017 GEOAccess reports show specialists (including hospitals and pharmacies) are measured as one within 50 miles/one within 75 minutes with results showing 100% compliance. The 2017 availability report - primary care providers and behavioral health providers showed 100% compliance to the standard for behavioral health providers.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Twice annually Select Health submits a complete listing of its provider network to comply with the SCDHHS report companion guide, as stated in policies NM 159.206, Availability of Practitioners and NM 150.304, Behavior Health Provider Availability. Select Health monitors the geographic availability annually and/or on an as needed basis to assess the sufficiency of the provider network.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy NM 159.101, Assessing the Cultural Responsiveness of the Provider Network addresses the procedures for ensuring the Select Health provider network meets the cultural and linguistic needs of its health plan membership. Race, ethnicity, and language data are collected from all contracted network providers. Office support staff languages are collected voluntarily through provider visits and the credentialing process. Member materials are available in Spanish and language translation services are available to members 24 hours per day, seven days per week. In addition, alternate print formats are available for printed materials including large print and Braille. The *2016 QAPI Evaluation* states “Select Health performs a bi-annual review of the language needs for the plan’s membership and provides an assessment of the provider network’s ability to adequately meet the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified membership needs and preferences. The Network Cultural Assessment will be conducted in 2017." Select Health confirmed the final report is expected in February 2018.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					The Select Health website's searchable Provider Directory is detailed and user friendly. A paper *Provider Directory* that contains appropriate information was received in the desk materials. Members can contact Member Services for a paper copy of the *Provider Directory*. All changes that are made to the Facets provider database during the business day are uploaded nightly to the online directory. Policy NM 159.308, Assessment of Physician Directory Accuracy defines the process of performing an annual evaluation of accuracy of provider data and demographics in the provider directory. Routine data updates are made to the online Provider Directory on a daily basis. Physician data are validated via credentialing/recredentialing process, through provider visits by provider network account executives, and receiving written and/or electronic correspondence indicating a change in demographic information. In addition, a random sample is selected for auditing and reporting of plan provider data accuracy on an annual basis.
3.Practitioner Accessibility						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy NM 159.203, Accessibility of Services establishes guidelines and standards to ensure accessibility of services to members. The policy states that on an annual basis PCPs and high volume/high impact specialty physicians are evaluated for compliance with the plan's established accessibility standards. Policy NM 159.306, Accessibility of Behavioral Healthcare Services defines appointment access standards for behavioral healthcare. Standards are evaluated annually with a goal of 95% compliance. Select Health conducted a telephonic survey July-August of 2017 to assess the appointment availability for PCPs and high volume/high impact specialists. The draft survey report (PCP and specialty [high volume, high impact] accessibility surveys) showed that high volume/high impact specialists did not meet the 95% compliance goal for appointment standards. Rates of compliance were particularly low among access for urgent and emergent care. Routine care standards were met for allergy, OB/GYN and Optometry. The low compliance rates among emergent and urgent care, for both existing and new patients, suggests that the high volume and high impact providers do not have appointment capacity to work those members in to meet the access standards. Overall appointment accessibility among primary care providers met the designated access rate of 95% for existing patients in all three appointment types. The rates of compliance, however, were particularly low for appointment access for new patient routine care and new patient urgent care. The rate for emergency care for a new member was just below the plan standard.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Select Health conducted a behavioral health appointment access study with results reported in the *QAPI 2016 Program Evaluation*. For urgent, routine, or post-discharge follow-up care, members are able to get a visit with their behavioral healthcare provider within the availability timeframes. For non-life threatening emergent care, 52% did not meet the timeframe. Page 16 of the *QAPI 2016 Program Evaluation* incorrectly lists the standard for urgent care as "within 10 business days" when it should reflect "within 48 hours." Results of the primary care physician afterhours survey conducted in 2016 showed that of 1095 calls to provider office locations, 98% (1073) of the provider locations met the "after hours" availability standard. The goal is to ensure that at least 90% of PCPs are in compliance with the standard. The 22 locations that did not meet the standard were educated and resurveyed during July and August with recommendations reported back to the Quality of Service Committee. *Recommendation: Continue to assess barriers and implement interventions to address the low results of the PCP and specialty (high volume, high impact) accessibility surveys. Implement interventions to address the low results for non-life threatening emergent care identified in the 2016 Behavioral Health Appointment Access Study. Update page 16 of the QAPI 2016 Program Evaluation which incorrectly lists the standard for urgent care as "within 10 business days" when it should reflect "within 48 hours."*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					The telephone provider access study conducted by CCME reflects that calls were successfully answered 55% of the time (143 out of 260). This included a new calculation of omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 39%, this year's study had a statistically significant increase in successful calls ($p<.01$). For those not answered successfully (n=117 calls), 72 (62%) were unsuccessful because the provider was not at the office or phone number listed. Of the 143 successful calls, 118 (83%) of the providers indicated that they accept Select Health, although six (4%) indicated that this occurred only under certain conditions. And of the 118 that accept Select Health, 91 (77%) responded that they are accepting new Medicaid patients. Regarding a screening process for new patients, 40 (45%) of the 88 providers that responded to the item indicated that an application or prescreen was necessary. Of those 40, 14 (35%) indicated that an application must be filled out whereas five (13%) require a review of medical records before accepting a new patient, and 13 (33%) required both. When the office was asked about the next available routine appointment, 67 (84%) of the 80 responses met contact requirements. While results of the telephone provider access study showed improvement, for calls that were sent to voicemail, it was noted that some of the personal voicemail messages did not match the provider name with the number listed. CCME would also recommend the plan explore ways for providers to report and update incorrect contact information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendations: Consider some of the following action steps: *1. Investigate voicemail responses, as some of the personal voicemail messages did not match the provider name with the number listed.* *2. Provide a way for enrollees to report a provider contact number that is inaccurate.* *3. Provide a simple Web interface for providers to update their current contact information.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Select Health conducts training within 30 calendar days for newly contracted providers, or provider groups on active status per Policy NM 159.102, Provider Orientation and Ongoing Training.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Policy PNO 170.205, Ongoing Provider Training, defines the procedure that Select Health will conduct annual provider trainings throughout the state. The provider Network Operations Communications Specialist will conduct provider specific training sessions. Policy NM 159.102, Provider Orientation and Ongoing Training addresses that training can be offered through site visits, in office visits, letters to providers, updates in the *Provider Manual*, newsletters or other mailings, or corrective action plans. All in-office training sessions are documented and trends are monitored for additional training opportunities.
II D. Primary and Secondary Preventive Health Guidelines						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. 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.	X					Policy IHCM 210 S, Clinical Practice Guidelines, states that Select Health implements evidence-based preventive and clinical health guidelines that are relevant to the member population. The policy states the following preventative health guidelines have been adopted: •Periodic Health Examinations in Children (Birth -20 years old) •Periodic Health Examinations in Adults (21-65 years and over) Additional guidelines such as immunization schedules are listed in the *QAPI 2017 Program Description*.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Practice guidelines are reviewed at least every two years and when more current information becomes available. Updated guidelines are posted on the Select Health website and communicated via the provider newsletter and/or fax blast. Guidelines are distributed to practitioners via the practitioner manual, the web and through direct mailings.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					Several practice guidelines such as ADHD-children and adolescents, adult ADHD, and depression in adults address behavioral health; however, it does not appear that Select Health has adopted guidelines to address substance abuse. *Recommendation: Consider adopting practice guidelines that address substance abuse.*
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services						
1. 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.	X					Policy IHCM 210 S, Clinical Practice Guidelines states "Select Health adopts preventive and clinical practice guidelines in order to improve member outcomes, deliver cost-effective care, and promote consistency in Providers' clinical practice." Guidelines are adopted from nationally recognized sources and/or in collaboration with board certified practitioners from appropriate specialties who would use the guideline. Clinical practice guidelines are reviewed from nationally established sources that develop the guidelines with a sound scientific basis, using clinical literature and expert consensus. The Quality of Clinical Care Committee (QCCC) reviews all clinical practice guidelines and recommendations are made to the QAPIC Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. 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.	X					Select Health distributes the practice guidelines to appropriate network practitioners by mail, fax, email, or website per Policy IHCM 210 S, Clinical Practice Guidelines. Annually, providers are reminded of the availability of these guidelines through the Plan website and provider newsletter.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy QI 205.011, Monitoring Continuity and Coordination of Care defines continuity and care coordination monitoring activities that are completed at least annually. These activities help to detect potential problems in the delivery of care to Select Health members. Monitoring occurs annually and includes activities such as medical record review, member complaint/grievance/ appeal/transfer data analysis, annual practitioner surveys for PCPs and specialists, quality of care events, discharge planning, and other activities defined in the policy.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Provider medical record review is conducted at least annually in conjunction with the plan's annual HEDIS survey. Policy QI 2015-009, Medical Record Review defines the medical record standards that comply with contract guidelines.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Providers are educated regarding the medical record documentation standards in the *Provider Manual*.
3. Medical Record Audit						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					Results of the 2017 medical record documentation review showed that a random sample of 20 PCPs was chosen for the review that was completed in May 2017. The overall compliance rate was 94.47%, exceeding the plan's goal of 90%. This represents a 2.41% decrease from the rate of 96.75% in 2016. While this change is statistically significant, low rates in two practices created this decline. The opportunity areas were specific to these practices and did not radiate across the population. Quality management provided direct education to both providers to address the deficits. As a result of the overall decline in the score when compared to 2016 results, Select Health will expand chart reviews to include clinical practice guidelines focused reviews. Additional reviews are planned for 2018 and 2019 as well.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities						
1. The MCO formulates and implements policies guaranteeing member rights and responsibilities and procedures for informing members of these rights and responsibilities.	X					Upon enrollment, all members are mailed a *Member Handbook* containing member rights and responsibilities. The process to obtain a copy of the Members' and Potential Members' Bill of Rights and Members' Responsibilities is published annually via the member newsletter and posted on the website.
2. Member rights include, but are not limited to, the right:	X					Member rights are included in Policy MEM 129.100, Member Rights and Responsibilities, the *Member Handbook*, the *Provider Manual*, and on the website.
2.1 To be treated with respect and with due consideration for his or her dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and it providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information including:	X					Policy MEM 129.107, New Member Orientation Calls indicates the *Member Handbook* and other new member materials are mailed to members within 30 calendar days of the plan's receipt of enrollment data from SCDHHS. ID cards are issued by the 15th day of the month in which the member is enrolled. Onsite discussion revealed that the new member packet, containing the *Member Handbook*, Notice of Privacy Practices, *Co-payment Reference Guide*, and *Quick Start Guide* is usually mailed within the first week after receipt of enrollment data. Updates to the *Member Handbook* are made periodically and are listed on the Member Handbook List of Changes found on Select Health's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Full disclosure of benefits and services included and excluded in their coverage;						
1.1.1 Benefits include direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Benefits include access to 2nd opinions at no cost including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, maximum allowable benefits and claim submission procedures;						
1.4 Any requirements for prior approval of medical care including elective procedures, surgeries, and/or hospitalizations;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services;						
1.7 Procedures for post-stabilization care services;						
1.8 Policies and procedures for accessing specialty/referral care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Policies and procedures for obtaining prescription medications and medical equipment, including applicable copayments and formulary restrictions;						The *Member Handbook* includes basic information on pharmacy coverage, authorization requirements, benefit limitations, and instructions to contact Member Services for more information.
1.10 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network, and providing assistance in obtaining alternate providers;						The *Member Handbook* states that members will be notified of a provider's termination in writing, that Select Health will assign the member to a new PCP, and that the member may call to select a different PCP. The *Member Handbook* states that members have the right to receive notice of "any significant changes in the benefits package at least thirty (30) calendar days before the intended effective date of the change. The benefits package includes services, benefits and providers."
1.11 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.12 Procedures for disenrolling from the MCO;						
1.13 Procedures for filing grievances and appeals, including the right to request a Fair Hearing through SCDHHS;						Basic information on appeals, grievances, and State Fair Hearings is provided in the *Member Handbook*.
1.14 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						Page 2 of the *Member Handbook* states the Provider Directory includes participating providers along with address, phone number, specialty, and whether the provider is accepting new patients. Members are instructed to contact Member Services for more information. The *Member Handbook* does not inform members that alternate languages spoken by providers are also listed in the Provider Directory.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise the Member Handbook to include that alternate languages spoken by providers are listed in the Provider Directory.
1.15 Instructions on how to request interpretation and translation services when needed at no cost to the member;						
1.16 Member's rights and protections, as specified in 42 CFR §438.100;						
1.17 Description of the purpose of the Medicaid card and the MCO's Medicaid Managed Care Member ID card and why both are necessary and how to use them;						
1.18 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Services toll-free telephone number, TTY number, and mailing address are included in the *Member Handbook*. The handbook states that members may email Member Services by using the secure email form found on the website. A fax number for Member Services is listed on page 2 of the *Member Handbook* but is not found in the table on page 34. *Recommendation: Include the Member Services fax number on page 34 of the Member Handbook.*
1.19 How to make, change and cancel medical appointments and the importance of canceling and/or rescheduling rather than being a "no show";						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.20 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						Information regarding EPSDT services and the recommended schedule for those services is included in the *Member Handbook* and on the website.
1.21 A description of Advance Directives, how to formulate an advance directive and where a member can receive assistance with executing an advance directive;						
1.22 Information on how to report suspected fraud or abuse;						Page 4 of the *Member Handbook* defines the terms "fraud" and "abuse" and informs members how to report suspicions of fraud and abuse to First Choice's Fraud and Abuse Hotline, First Choice's Compliance Hotline, and South Carolina's Division of Program Integrity Fraud and Abuse Hotline.
1.23 Additional information as required by the contract and by federal regulation;						
1.24 The MCO notifies each member, at least once per year, of their right to request a Member Handbook or Provider Directory.						
2. Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network.	X					Requirements and processes for notifying members of changes to services, benefits, and providers are addressed in the following policies: •MEM 129.105, Member Services Department •MEM 129.117, Termination of Primary Care Provider •MEM 129.125, Termination of a Specialist or Hospital.
3. Member program education materials are written in a clear and understandable manner and meet contract requirements.		X				During onsite discussion, Select Health staff stated member materials are written at 6th grade reading level, and the reading level is confirmed by the Flesh-Kincaid method as well as by using Health Literacy Advisor™ software.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The requirements for reading level and font size for member materials found in the *SCDHHS Contract, Sections 3.16.1.2* and *3.16.1.3* were not addressed in policies submitted for desk review. Staff stated they believed a policy is in place and would submit the policy to CCME for review. At the time of this report, no policy has been received. *Quality Improvement Plan: Define the contractual requirements for reading level and font size for member materials and Select Health's processes for ensuring compliance with those requirements in a new or existing policy.*
4. The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages.	X					The *Member Handbook* and other member materials contain the toll-free telephone number and normal business hours for Member Services. The toll-free telephone number for the Nurse Help Line, available 24 hours a day, 7 days a week, is also provided. Normal business hours for Member Services are 8:00 am to 9:00 pm, Monday through Friday. Weekend hours are 8:00 am to 6:00 pm, and holiday coverage is ensured via a rotating schedule. After hours, members may leave voicemail messages—these messages receive a response within 1 business day. Language Service Associates (LSA) provides telephonic translation/interpretation services for members and providers. LSA is available 24 hours per day, 7 days per week and can provide translation for over 200 languages. This service can be accessed by contacting Member Services or the 24-hour Nurse Help Line.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed.	X					
III C. Member Disenrollment						
1. Member disenrollment is conducted in a manner consistent with contract requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed.	X					Policy MEM 129.109, PCP Selection and Changes indicates members must choose a network PCP. Members may elect to choose a nurse practitioner to be their PCP, but Select Health does not auto-assign members to nurse practitioners. If the member has not already selected a PCP, Member Services staff encourage early PCP selection during outreach calls to new members within 14 days of enrollment. If contact with the member is unsuccessful, a PCP is assigned using a systematic algorithm which considers other family members with an assigned PCP, the geographic proximity to a PCP, and age and gender appropriateness of the PCP. Members may select or change their PCP by contacting Member Services or by using the Member Portal on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits.	X					When accessing members' records, Member Services staff see care gaps for the member so that they can encourage the member to receive the past-due or recommended service. Per Policy QI 154.006, EPSDT/ Prevention and Screening Outreach the secure Member Portal allows members to see when they and their dependents are due for well visits or other services. Multiple outreach campaigns are in place using postcards, automated messages, letters, etc. to encourage members to obtain recommended services.
3. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care.	X					Methods of identifying pregnant members include assessment information provided by obstetrics providers, new enrollee assessments, claims and pharmacy data, inter-departmental referrals, self-referrals, member outreach, the 24-Hour Nurse Line, and Select Health nursing assessments. The Maternal Child Management Program (Bright Start®) provides dedicated prenatal care managers to follow high- and moderate-risk members to coordinate care and address issues throughout the pregnancy and postpartum period. Low-risk members are provided with educational materials and have access to a maternal child care manager or care connector for questions or concerns.
4. The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO provides educational opportunities to members regarding health risk factors and wellness promotion.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to:	X					Select Health contracts with Morpace, a certified CAHPS survey vendor, to conduct the adult and child surveys. Response rates for 2017 showed only a slight increase over the 2016 response rates—from 23% to 24% (child) and from 20% to 21% (adult). *Recommendation: Continue working with vendors to increase response rates. Possible ways to increase response rates could include announcing the survey in bulletins and on websites and adding a reminder to call center scripts. Decide upon an internal goal to increase response rates (such as a 2% increase each year).*
1.1 Statistically sound methodology, including probability sampling to insure that it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Claim processing procedures;	X					
1.6 Adverse decisions regarding MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality problems.	X					Morpace summarizes and details all results from the Adult and Child surveys. Select Health identified problem areas in adult and child CAHPS surveys.
3. The MCO implements significant measures to address quality problems identified through the member satisfaction survey.	X					The Quality Management Department, Utilization Management Department, and the Quality Assurance Performance Improvement Committee were involved in generating interventions/initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Member satisfaction results were reported to providers on the website under the Quality tab.
5. The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified.	X					
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:	X					Policy MMS.100, Member Grievances and Appeals Process defines procedures for receipt and resolution of member grievances. It was noted that this policy was a Member Services policy and is now a joint policy with Medical Management.
1.1 Definition of a grievance and who may file a grievance;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 The procedure for filing and handling a grievance;	X					Procedures for filing and handling grievances are correctly and consistently documented in Policy MMS.100, Member Grievances and Appeals Process, the *Member Handbook*, and the *Provider Manual*. Select Health does not have a specific timeframe for filling a grievance. According to policy MMS.100, Member Grievances and Appeals Process a grievance may be filed at any time. Acknowledgement letters are created and mailed within one business day of receipt of the grievance. Select Health assists members in the grievance filing process by arranging and/or providing auxiliary aids and services or language assistance service if needed to participate in the grievance process. These arrangements can include providing interpreters, visual aids, barrier-free locations for the proceedings, completing forms, and other procedural steps.
1.3 Timeliness guidelines for resolution of the grievance as specified in the contract;	X					Documentation of timeliness requirements for grievance resolutions, as well as information on extensions of resolution timeframes, is found in Policy MMS.100, Member Grievances and Appeals Process, the *Member Handbook*, the *Provider Manual*, and in the Grievance Acknowledgement Letter. Per Policy MMS.100, standard resolution of grievances including notice to the affected parties may not exceed 90 calendar days.
1.4 Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract.	X					Grievance logs and records are retained for 10 years. If any actions (i.e. litigation) involving documents or records has been started before the expiration of the 10-year period, the records are retained until completion of the action and resolution of the issue. Written member grievance logs are provided to the State on a quarterly basis.
2. The MCO applies the grievance policy and procedure as formulated.			X			Twenty grievance files were reviewed, and all were found to be timely. Issues identified include: •One file did not contain a resolution letter. •One file reflected an inappropriate resolution that the member was financially liable for an emergency room visit at an out-of-network facility. The resolution letter indicated the provider did not obtain authorization. However, emergency services do not require prior authorization as noted on page 10 of the *Member Handbook*. Also, according to the *SCDHHS Contract, Section 4.2.11.1*, "the Contractor shall provide emergency services without prior authorization" and "promptly pay for emergency services regardless of whether the Provider has a contract with the Contractor consistent with 42 CFR § 438.114 (c)(1)(i)." This was an issue identified during the previous EQR. *Quality Improvement Plan: Ensure members are not held liable for emergency services regardless of whether the Provider has a contract with Select Health.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					An annual summary of all member grievances is reported to the Quality of Service Committee for evaluation and recommendations. Additionally, grievances are evaluated mid-reporting year to identify trends prior to the annual summary report. Policy MMS.100, Member Grievances and Appeals Process states "In compliance with the Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services (CLAS), the grievances and appeals supervisor will forward all culturally-related grievances and appeals to SHSC's CLAS Coordinator who is responsible for cataloguing and monitoring culturally-related grievances and appeals." Onsite discussion revealed the position of CLAS Coordinator no longer exists. *Recommendation: Remove the reference to the CLAS Coordinator from Policy MMS.100, Member Grievances and Appeals Process.*
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Select Health's *Quality Assessment and Performance Improvement 2017 Program Description* outlines the program in place for measuring and improving the care and services received by members and providers. The Quality Assurance Performance Improvement Committee, Regional Chief Medical Officer, and the Director of Quality Management are responsible for planning, designing, implementing, and coordinating all QI activities. Dr. Fred Hill serves as the Regional Chief Medical Officer and Faleshia Jones is the Director of Quality Management. The approval page of the *Program Description* was blank. This was discussed during the onsite and staff indicated the document is presented to the Quality Assurance Performance Improvement Committee (QAPIC) for review and approval. Select Health's 2017 annual work plan and *Program Description* include delegation oversight and monitoring. However, the list of delegates on page 37 of the *Program Description* does not include all the delegates. The list only included the credentialing delegates whereas the work plan included utilization and credentialing delegates. *Recommendation: The approval signature page of the Quality Assessment and Performance Improvement Program Description should be completed once*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						approval is obtained. Update the delegation list in the program description and in the work plan to include all delegation activities.
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					One of the responsibilities listed for the QAPIC is to monitor and review practitioner and provider performance with respect to the application of clinical practice guidelines. Quality measures are incorporated into PCP report cards, which provide direct feedback on practitioners' performance, compared to a peer group on key quality measures. Report cards are provided annually.
3. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					
4. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, Select Health develops a work plan to guide and keep track of all QI activities. The 2016 and 2017 work plans were provided with the desk materials. Both included activities to be conducted, objectives for each activity, overall goal, person(s) responsible, and monitoring frequency.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QAPIC Committee provides oversight for all quality, Utilization Management and integrated health care management activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The market president serves as chairperson for the QAPIC and membership includes a variety of network providers and health plan leadership staff.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A quorum is defined as 50% of voting member present during the meeting. Committee minutes demonstrated the quorums were met.
3. The QI Committee meets at regular quarterly intervals.	X					The QAPIC meets bi-monthly or at a minimum of five times per year.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					For the performance measures, Inovalon certified software for HEDIS measure calculation was used, and the measures were fully compliant and consistent with the requirements of the CMS protocol. There were concerns regarding a few of the rates, such as statin adherence, which had large decreases in rates. Otherwise, the HEDIS measures had slight changes or improvement.
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.	X					Two projects were submitted and validated using the CMS Protocol for Validation of Performance Improvement Projects. They were: Diabetes Outcomes Measures and Follow-up After Hospitalization for Mental Illness at 7 and 30 days After Discharge.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".		X				The Diabetes Outcomes Measures scored within the High Confidence range and the Follow Up After Hospitalization for Mental Illness at 7 and 30 days After Discharge scored in the Confidence range.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Both projects are considered new initiations and include baseline data only. The documentation for both projects did not include adequate information regarding staff who work with data and their qualifications. The complete validation results can be found in *Attachment 3, EQR Validation Worksheet*. *Quality Improvement Plan: Correct the errors Identified in the Performance Improvement Project documents.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Select Health encourages network providers to participate in QI program activities by committee participation and through the practitioner performance.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Quality measures are incorporated into PCP report cards that provide direct feedback on practitioners' performance, compared to a peer group on key quality measures. Report cards are provided annually.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					The QI program is evaluated at least annually. The *Quality Assessment and Performance Improvement 2016 Program Evaluation* was presented in the desk materials.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. UTILIZATION MANAGEMENT						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The *Integrated Utilization Management Program Description* is specific to the SC Medicaid managed care line of business, and addresses the scope, goals, and objectives of the Utilization Management (UM) Program, as well as the lines of responsibility within the program and an overview of various UM processes and functions. UM policies provide further information on UM requirements and processes. UM policies are reviewed and updated no less than annually.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					The structure of the UM Program is provided in the *UM Program Description*. Methodology used to evaluate medical necessity is addressed in various UM policies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 lines of responsibility and accountability;	X					Lines of responsibility and accountability are defined in the *UM Program Description*.
1.3 guidelines / standards to be used in making utilization management decisions;	X					Guidelines and standards used for medical necessity determinations are defined in the *UM Program Description* and Policy UM.008S, Clinical Criteria.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				Requirements for the timeframes in which authorization determinations must be made are defined in the *UM Program Description* and Policy UM.010S, Timeliness of UM Decisions. Page 19 of the *Member Handbook* provides authorization timeframes and information on extensions, but it does not explain who can request an extension of the authorization timeframes. Page 30 of the *Provider Manual* defines authorization timeframes, but it does not include information on extensions of authorization timeframes or who may request an extension. *Quality Improvement Plan: Revise the Member Handbook to explain who can request an extension of authorization timeframes. Update the Provider Manual to include information on extensions of authorization timeframes, who may request an extension, and circumstances under which Select Health may extend the timeframes.*
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					All Select Health employees are required to adhere to the Code of Ethics and Conduct, which is distributed to and reviewed with staff upon hire and annually

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						thereafter. The Code of Ethics and Conduct includes the following: •UM decisions are based only on appropriateness of care and service and existence of coverage. •Providers, associates, or other individuals conducting utilization review are not rewarded by Select Health for issuing denials of coverage or service. •Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.
1.7 the mechanism to provide for a preferred provider program.		X				Information in the submitted desk materials did not include documentation of a Preferred Provider Program established to meet the requirements of the *SCDHHS Contract, Section 8.5.2.8.* During onsite discussion, Select Health staff indicated that a program is in place that eliminates the need for initial notification of pregnancy by obstetrical providers. This discussion did not provide sufficient evidence that a Preferred Provider Program in which providers may obtain preferred provider designation based on quality has been established. Select Health staff indicated the documentation to illustrate Select Health's compliance with this requirement would be submitted to CCME for review. At the time of this report, no documentation has been received. *Quality Improvement Plan: Develop and implement a Preferred Provider Program that meets the requirements of the SCDHHS Contract, Section 8.5.2.8.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is updated annually with approval from the QAPIC. Clinical criteria are reviewed and updated annually by the Quality of Clinical Care Committee (QCCC), which includes plan Medical Directors as well as community-based participating physicians.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of approval files confirmed that requests for additional information were made when needed and the use of appropriate criteria for the determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Policy UM.008S, Clinical Criteria confirms staff must consider individual member factors and characteristics of the local health delivery system when applying UM medical necessity criteria. Member considerations include age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment. Local delivery system considerations include availability of sub-acute care facilities or home care in plan service area for post discharge support, plan benefits for sub-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						acute care facilities or home care where needed, and ability of local hospitals to provide all recommended services within the estimated length of stay.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Select Health has established processes to ensure consistent and uniform application of clinical criteria, as defined in Policy UM.708S, Inter-rater Reliability. Inter-rater reliability (IRR) tests are administered to clinical UM staff, behavioral health clinicians, and Medical Directors. Review results are summarized and forwarded to the QCCC and QAPIC, and they are included in the yearly UM program evaluation. Results are used to identify needs for additional training and development. Review of committee minutes and the UM program evaluation reflect Select Health staff consistently exceed the scoring benchmark of 90% for IRR testing.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Select Health's website includes both a searchable Online Preferred Drug List (PDL) and a downloadable PDL. Changes to the PDL are noted on the website's Preferred Drug List Changes document after each quarterly Pharmacy and Therapeutics (P&T) Committee meeting, and at least 30 days before the implementation of the change. The P&T Committee oversees the development, implementation, and maintenance of formulary strategies and other drug utilization controls. It approves inclusion or exclusion of drugs on the formulary/PDLs annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Processes and requirements for coverage of emergency and post-stabilization services are defined in Policy UM.905S, Emergency Room Services. Page 3 of the policy states, "If SHSC and the treating provider cannot reach an agreement concerning the member's care and a network provider is not available for consultation. In this situation, SHSC shall give the treating provider the opportunity to consult with a network provider, and the treating provider may continue with the care of the member until a network provider is reached or one of the criteria of 42 CFR §422.113(c)(3) is met." The policy does not specify what the criteria found in the regulation are, and this could limit employee understanding of the requirements. *Recommendation: Revise policy UM.905S, Emergency Room Services to specify what the criteria in 42 CFR §422.113(c)(3) are.*
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Determination and notification timeframes in the approval files reviewed were compliant with established requirements.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					Denial files contained evidence that additional clinical information was requested when necessary prior to rendering the determination.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					For two denial files reviewed, it wasn't clear which Medical Director/designee reviewed the request and issued the denial determination. *Recommendation: Ensure denial files clearly reflect the reviewer who issues denial determinations.*
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					The denial files reviewed reflected determination notifications were sent within the required timeframes. One of the adverse benefit determination letters did not indicate the criteria reviewed to render the determination. *Recommendation: Ensure all adverse benefit determination letters clearly indicate the criteria used in the review and decision-making process.*
V C. Appeals						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy MMS.100, Member Grievances and Appeals Process defines procedures for receipt and resolution of member appeals. At the time of submission of the desk materials, this policy was pending approval by SCDHHS. Onsite

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						discussion confirmed the policy was approved by SCDHHS on October 26, 2017, and is now in effect.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				The definitions of an adverse benefit determination and an appeal are appropriate in Policy MMS.100, Member Grievances and Appeals Process and the *Member Handbook*. Pages 34-35 and 74 of the *Provider Manual* appropriately define an appeal, but they incompletely define an adverse benefit determination. They do not include "The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." Refer to the *SCDHHS Contract, Section 9.1 (b)* and *Federal Regulation § 438.400 (b)*. Information defining who may file an appeal is appropriately documented in Policy MMS.100, Member Grievances and Appeals Process, the *Member Handbook*, and the *Provider Manual*. *Quality Improvement Plan: Revise the Provider Manual to include the complete definition of an adverse benefit determination as stated in the SCDHHS Contract and Federal Regulation.*
1.2 The procedure for filing an appeal;		X				Issues identified with documentation of appeal filing procedures include: •Page 25 of the *Provider Manual* incorrectly states, "Appeals must be filed within 60 calendar days from the date of receipt of denial or action notification." All other documents are compliant with the contract requirement of 60 calendar from the date on the adverse benefit determination notice. Refer to the *SCDHHS Contract, Section 9.1.1.2.2.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Page 35 of the *Provider Manual* states, "If the member or authorized representative does not follow up with written confirmation within thirty calendar days of initiating an oral appeal, the appeal may be dismissed. If the written confirmation is received after thirty calendar days from the date of filing an oral appeal request but is within the ninety calendar day filing period, the thirty calendar day resolution time frame will begin at the time of receipt of written confirmation." The reference to the 90-calendar day filing period is incorrect. Refer to the *SCDHHS Contract, Section 9.1.1.2.2.* *Quality Improvement Plan: Revise the Provider Manual to reflect the correct timeframe for filing an appeal. Correct the reference to the appeal filing period of 90 calendar days in the Provider Manual.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Documentation of appeal resolution timeframes and extensions of those timeframes is correct in Policy MMS.100, Member Grievances and Appeals Process, the *Member Handbook*, and the *Provider Manual*.
1.6 Written notice of the appeal resolution as required by the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Other requirements as specified in the contract.		X				An error in the timely filing requirement for continuation of benefits is noted in the bulleted list on page 27 of the *Member Handbook*. It states the member's benefits will be continued if the member files the appeal timely, within 60 calendar days from the date on the adverse benefit determination notice. The correct timeframe is within 10 calendar days of the mailing date of the notice of adverse benefit determination. Refer to the *SCDHHS Contract, Section 9.1.7.1.1.* When defining the timeframe for timely filing for continuation of benefits, an incorrect reference to a federal regulation is noted on page 8 of Policy MMS.100, Member Grievances and Appeals Process. It states, "The member or the representative files the appeal timely in accordance with 42 CFR section 438.402(c)(1)(ii) and (c)(2)(ii)." The correct reference is *§ 438.420 (a) (i) and (II).* *Quality Improvement Plan: Correct the timely filing timeframe for continuation of benefits in the bulleted list on page 27 of the Member Handbook. Revise Policy MMS.100, Member Grievances and Appeals Process to include the correct federal regulation reference for timely filing requirements for continuation of benefits.*
2. The MCO applies the appeal policies and procedures as formulated.	X					Review of appeal files revealed timely appeal determinations by appropriate reviewers. Issues noted in the files included: •Two appeal resolution letters were not compliant with the notification timeframe requirement. Select Health staff stated during the onsite interview that this issue has already been identified and corrected.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Discrepancies in documentation of the receipt date of 3 appeals were noted. This could result in untimely acknowledgement or resolution of the appeal. *Recommendation: Ensure appeal resolution letters are sent in compliance with required timeframes. Ensure the receipt date of appeals is accurately documented throughout the appeal case file to ensure timely acknowledgement and resolution.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Case Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The *Integrated Health Care Management (IHCM) Program Description* and case management (CM) policies describe the case management/care coordination programs.
2. The MCO has processes to identify members who may benefit from case management.	X					Policy IHCM 202 S, Referral To Integrated Health Care Management states members are identified for CM through a variety of sources (providers, on-site care managers, internal departments, other CM programs, claims/pharmacy encounter data, and self-referral). SCDHHS refers members that have been identified through a pharmacy lock-in program or through daily operations. During onsite discussion, it was confirmed that Member Services staff conduct an initial health risk screening for new members within the first 90 days of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						enrollment. Documentation of this process was not found in policy or in the *IHCM Program Description*. *Recommendation: Include the process for conducting initial health risk screenings in a policy or in the IHCM Program Description.*
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy UM.706S, Continuity of Care and Policy IHCM 301 S, MCO Transition Coordinator define requirements and processes for care transitions.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements	X					Policy IHCM 301 S, MCO Transition Coordinator defines the role and responsibilities of the Transition Coordinator.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					Select Health uses IHCM member satisfaction surveys and complex care management satisfaction surveys to gauge member satisfaction with case management services.
7. Care management and coordination activities are conducted as required.	X					CM files were found to be thoroughly documented with appropriate assessments, care plans, follow-up, and monitoring.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract.	X					Select Health's processes for detecting and documenting under- and over-utilization are documented in Policy 154.012, Over and Under Utilization.
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Select Health analyzed and monitored data and offered recommendations based on findings for several UM topics in committee meetings and in the UM annual evaluation.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
1. The MCO has written agreements with all subcontractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.		X				Select Health ensures written agreements for all entities performing delegated functions. The agreements outline requirements such as responsibilities, reporting requirements, oversight activities, and actions that may be taken for substandard performance. Policy 277.010, Delegation Oversight defines the processes for pre-delegation assessment of delegate capabilities along with annual oversight of delegate performance. Policy CR.101.SC, Delegation of Credentialing and Recredentialing Activities defines the processes for delegated credentialing and recredentialing activities. Exhibit A details the delegated credentialing agreement and Exhibit B details state specific credentialing requirements. Several references throughout the policy and exhibits incorrectly refer to language regarding initial onsite reviews that must be conducted for all PCPs. In addition, Exhibit B contains references to the 2014 *SCDHHS Contract* and the 2014 *P&P Guide* throughout the document. This outdated document is also used as a SC Medicaid audit tool for the annual oversight reviews. *Quality Improvement Plan: Update Policy CR.101.SC and exhibits to remove the outdated language regarding initial onsite reviews for all PCPs. Update Exhibit B to remove outdated language and references to the 2014 SCDHHS Contract and P&P*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Guide. This document should reflect current SCDHHS Contract and P&P Guide language.
2. The MCO conducts oversight of all delegated functions sufficient to insure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Evidence of annual oversight review was received for all delegated entities. For delegated credentialing, Select Health uses an NCQA tool where specific information is detailed for each credentialing/ recredentialing file reviewed, and they use a SC Medicaid audit tool specific to *SCDHHS Contract/P&P Guide* requirements. As previously mentioned, this SC Medicaid audit tool does not reflect current *SCDHHS Contract*/P&P Guide language, and it was difficult to determine how SC credentialing requirements were taken into consideration for the file review. The delegate file review was documented on the NCQA tool and comments in the SC Medicaid audit tool appeared to only address a review of policies and documents. Select Health documents the delegated entity's overall findings on the *2017 Credentialing Delegation Executive Summary* sheet. Two delegated entities (Georgia Regents/AU Medical Center and Health Network Solutions) did not indicate that the ownership disclosure forms had been reviewed. Health Network Solutions' Executive Summary also indicated that a file review had not been completed due to NCQA CVO certification. Onsite discussion confirmed that SC credentialing requirements were reviewed and any issues would have been documented in the summary section of the tool. However, there did not appear to be documentation confirming SC credentialing criteria were considered. Overall Select Health is conducting oversight of their delegated entities but there is room for improvement

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						through ensuring the oversight tools reflect current requirements and that file review documentation clearly shows *SCDHHS Contract/P&P Guide* requirements are being taken in to consideration. *Quality Improvement Plan: For entities where credentialing has been delegated, ensure the credentialing/recredentialing file review tool reflects SC credentialing/recredentialing requirements. Ensure ownership disclosure forms are reviewed and all entities have a file review to assess compliance to SC credentialing guidelines.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V II. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Select Health conducts PCP medical record review at least annually in conjunction with the plan's annual HEDIS survey. Among the items for which the records are audited are: •Past medical history related to prenatal care, birth, childhood illnesses, surgeries, and immunization record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Evidence that preventative screening and services are offered in accordance with Select Health practice guidelines Policy QI 154.006, EPSDT/Prevention and Screening Outreach defines Select Health's processes to notify and remind providers of needed EPSDT services. Lists of members due for well visits (EPSDT), immunizations, and lead screening are mailed to PCPs on a quarterly basis. The Navinet provider portal allows PCPs to view care gaps for their assigned members. Treo Solutions is an additional provider portal which displays member care gaps. Provider account executives review care gap lists with primary care providers during quarterly face-to-face meetings.
1.2 performing EPSDTs/Well Child Visits.	X					
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Errors in Select Health's grievance process that were identified during the previous EQR were not corrected. *Quality Improvement Plan: Ensure all deficiencies identified during the EQR are corrected and the corrections are implemented.*