CCME

2018 External Quality Review

SELECT HEALTH OF SOUTH CAROLINA

Submitted: December 07, 2018

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and results of the *2018 External Quality Review (EQR)* conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Select Health of South Carolina (Select Health) since the 2017 annual EQR.

The goals of the review are to:

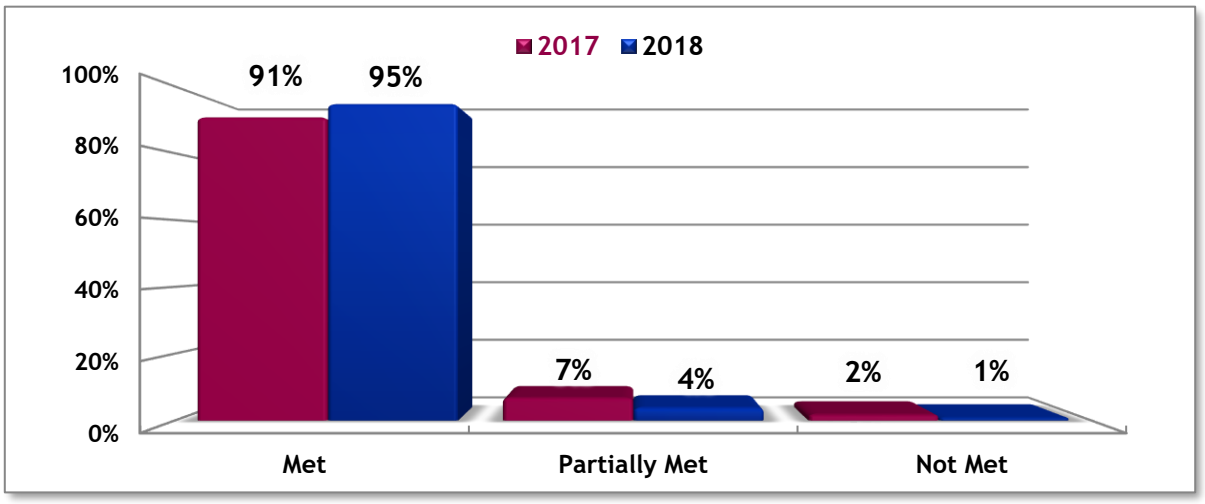
- Determine if Select Health is in compliance with service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the 2017 annual EQR and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement
- Validate the plan delivers contracted health care services that are of good quality

The process CCME uses for the EQR is based on the protocols developed by the Centers for Medicare & Medicaid Services (CMS) for Medicaid MCO EQRs. The review includes a desk review of documents, a two-day Onsite visit, a telephone access study, compliance review, performance improvement project (PIP) validation, performance measure (PM) validation, and satisfaction survey validation.

Overall Findings

The 2018 annual EQR shows that Select Health achieved a "Met" score for 95% of the standards CCME reviewed. As the following chart indicates, 7% of the standards are scored as "Partially Met," and 1% of the standards are scored as "Not Met." The chart that follows provides a comparison of 2018 review results with 2017 results.

Figure 1: Annual EQR Comparative Results



An overview of the findings is included in the respectively labeled sections of the Executive Summary. Details of the review as well as specific strengths, weaknesses, any applicable quality improvement items, and recommendations are found in the respectively labeled sections of the complete report.

Administration

Select Health is subsidiary of AmeriHealth Caritas. First Choice is the Select Health Medicaid health plan in South Carolina. Select Health's organizational chart revealed several vacancies; however, CCME confirmed that several of the vacant positions were filled since the plan submitted the organizational chart to CCME, and recruitment/hiring activities to fill the remaining vacancies are underway.

Appropriate processes are in place to ensure policies are reviewed at least annually, revised as needed, and that staff are made aware of new or revised policies. Staff have access to policies via a shared network drive and a local intranet site.

Select Health leverages the resources of its parent company, AmeriHealth Caritas, to perform much of its data processing and data management. The Information Systems Capabilities Assessment (ISCA) documentation indicates these resources are up-to-date, secure, regularly monitored, and audited annually. Based upon the data provided, CCME has determined that Select Health has the capability to meet or exceed the *SCDHHS Contract* requirements.

Select Health's *Compliance Program and Program Integrity Plan* and associated policies define requirements and guide staff executing Compliance and Program Integrity functions. Select Health has an established Code of Conduct and Ethics (Code) that provides comprehensive information and guidance about standards of ethical behavior

and compliance with federal and state laws. All staff, including the Board of Directors (BOD), officers, contingent staff, subcontractors, and vendors, is expected to abide by the Code. Select Health provides annual training on compliance topics to ensure staff understands expectations for compliance with the Code of Conduct and Ethics. The Compliance Committee monitors the Compliance Program.

Provider Services

Dr. Kirt Caton, Market CMO, chairs the Credentialing Committee. Additional voting members include a Behavioral Health Medical Director, Regional UM Medical Director, a network Certified Registered Nurse Practitioner, and four network physicians specializing in pediatrics, family practice, and orthopedic surgery. Select Health also has three additional members (two Medical Directors and an obstetrics (OB)/gynecology (GYN) network physician) on an ad hoc basis, and they vote only when they attend a meeting. CCME review of committee meeting minutes reflected quorums were met and active participation by committee members.

The credentialing policy is detailed; however, it does not address how the plan takes provider performance into consideration during recredentialing. The recredentialing file review showed the majority of the recredentialing files contained outdated Ownership Disclosure Forms.

Policies define network accessibility, provider availability standards, and procedures for assessing the network. Select Health conducts telephonic surveys to assess provider adherence to appointment standards for Primary Care Physicians (PCPs), high-volume/high-impact specialists, and behavioral health providers; however, this process is not addressed in the Accessibility of Services Policy or the Accessibility of Behavioral Healthcare Services Policy. Results of the telephonic surveys show the 95% goal for existing patients for Emergent, Urgent, and Routine care as met. New patient access to primary care is trending lower than desired. The High Volume and High Impact Specialties were not met for many of the specialists evaluated, in particular for new patients. Prescriber and Non-Prescriber accessibility results fell below the 95% compliance goal for all behavioral health access standards.

Results of the *Telephonic Provider Access Study*, conducted by CCME, reflected calls were successfully answered 50% of the time (113 out of 224). When compared to 2017 results (55%), the 2018 study showed no improvements in the successfully answered calls.

Member Services

Select Health's Member Services Call Center is located in South Carolina and is staffed during contractually required hours. Select Health exceeds contractual requirements by also staffing the call center on weekends from 8:00 a.m. to 6:00 p.m. Members are provided with a toll-free telephone number to contact the call center, and Text

Telephone (TTY) services are available. Outside of normal business hours, callers have the option to leave a confidential voice message or speak with the Nurse Help Line, available 24-hours a day, seven days a week.

Processes are in place to educate new members about the health plan, including a packet of information mailed to new members within 30 calendar days of enrollment. Additionally, the plan conducts new member orientation calls within two weeks of enrollment. Select Health maintains a *Member Handbook List of Changes* on its website. CCME identified a few issues with information in the *Member Handbook* and offered actions to correct the information during the Onsite visit.

Response rates for 2018 Adult and Child Consumer Assessment of Healthcare Providers and Systems® (CAHPS) surveys reflect no improvement over the 2017 response rates, yet the Child Medicaid, Children with Chronic Conditions (CCC) total sample response rate for 2018 increased slightly. All response rates continue to fall below the National Committee for Quality Assurance (NCQA) target response rate of 40%.

Grievance requirements and processes are well-documented in policy, the *Member Handbook*, and the First Choice website. CCME noted a few, easily-correctable issues related to grievance documentation in the *Provider Manual*. The grievance files reflect timely determinations and grievance resolution notifications; however, issues exist in the contents of grievance resolution letters, including use of pre-formulated, standard verbiage that does not correspond to the investigation and resolution documented in the file. Files also include insufficient information for members to understand how grievances are resolved.

Quality Improvement (QI)

The Select Health *2018 Quality Assessment Performance Improvement Program Description* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. Select Health evaluates the effectiveness of its QI Program annually. For this review, Select Health provided the *Quality Assessment Performance Improvement 2017 Program Evaluation*. This report provides a high-level assessment of the results of 2017 QI activities. In some of the analysis of the Health Effectiveness Data Information Set (HEDIS®) measures, the plan was unclear about the reported rate for the calendar year, or the analysis indicates a reduction in the rate when there is an increase in the reported rate. The report identifies barriers, interventions, and improvement opportunities.

The performance measures and performance improvement projects met the CMS validation requirements. Comparison of the HEDIS measures from the previous year to the current year reveal a notable increase in Body Mass Index (BMI) Percentile Documentation and Follow-Up Care for Children Prescribed ADHD Medication Continuation and

Maintenance. The most problematic performance measure is Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) for 1- to 5- year-olds, which reflects a 20% decrease over the prior year (see *Table 1: HEDIS Measures*).

Table 1: HEDIS Measures

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	71.53%	83.46%	11.93%
Counseling for Nutrition	59.03%	62.47%	3.44%
Counseling for Physical Activity	56.25%	59.75%	3.50%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	43.14%	42.10%	-1.04%
Continuation and Maintenance Phase	28.79%	53.75%	24.96%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	60.00%	40.00%	-20.00%
6-11 Years	67.01%	64.45%	-2.56%
12-17 Years	64.19%	56.01%	-8.18%
Total	65.05%	58.37%	-6.68%

In 2017, the plan submitted and CCME validated two new projects. They were: Diabetes Outcomes Measures and Follow-up After Hospitalization for Mental Health Within 7 and 30 Days After Discharge. Both projects contained baseline data only, and the primary issues were documentation of personnel and data analysis matching the data analysis plan. For this review, those same PIPs were validated. *Table 2, Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

TABLE 2: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Diabetes Outcomes Measures: Clinical	96/103= 93% High Confidence in Reported Results	110/111=99% High Confidence in Reported Results

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Follow-up After Hospitalization for Mental Health Within 7 and 30 Calendar Days After Discharge: Non-Clinical	84/96= 88% Confidence in Reported Results	91/91=100% High Confidence in Reported Results

Both projects scored within the High Confidence range with only minor errors in the Diabetes PIP. There were issues regarding the p-values. In the results section, the actual p-value that is a result of the comparison should be documented. It should be p=.652 for the first measure, p=.230 for HbA1C<8, and p=.009 for controlling BP <140/90. Instead of <.00001, the calculated p-value should be presented on pages 10,11, and 12 of the project documents.

Utilization Management (UM)

CCME's assessment of UM includes reviews of program descriptions, program evaluations, policies, committee minutes, corresponding reports, and appeal, approval, denial, and case management (CM) files. UM policies and procedures define how UM, medical necessity determinations, appeals, and CM services are operationalized and provided to service members.

The *Integrated Utilization Management Program Description* outlines the purpose, goals, objectives, and staff roles for physical and behavioral health. The newly implemented population health management strategy uses a multi-disciplinary approach in core components to provide services addressing all risk levels.

Select Health monitors and analyzes under- and over-utilization of medical services as required by the contract.

Delegation

Select Health ensures all delegation arrangements are governed by written agreements between the delegate and the plan through a *Delegation Agreement*. Delegation oversight is conducted for delegated entities through a pre-delegation assessment for new delegates and annual oversight for existing delegates. Evidence of oversight was received for all delegated entities. One delegation policy had an attachment that contained outdated *SCDHHS Contract* and *SCDHHS Policy and Procedure Guide* references; however, the tools used for annual oversight were updated and appropriate.

State Mandated Services

Provider compliance with provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations is monitored through medical

record reviews conducted by nurse reviewers. Select Health provides all core benefits specified by the *SCDHHS Contract*.

*Table 3, Scoring Ove*rview provides an overview of the findings of the current annual review compared to the 2017 review findings.

Table 3: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2017	39	0	0	0	0	39
2018	40	0	0	0	0	40
Provider Services						
2017	69	7	2	0	0	78
2018	73	4	1	0	0	78
Member Services						
2017	31	1	1	0	0	33
2018	29	4	0	0	0	33
Quality Improvement						
2017	14	1	0	0	0	15
2018	15	0	0	0	0	15
Utilization						
2017	40	5	0	0	0	45
2018	45	0	0	0	0	45
Delegation						
2017	0	2	0	0	0	2
2018	1	1	0	0	0	2
State Mandated Services						
2017	3	0	1	0	0	4
2018	4	0	0	0	0	4

METHODOLOGY

The process used by CCME for EQR activities is based on protocols developed by the Centers for Medicare & Medicaid Services (CMS) for the external quality review (EQR) of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures (PMs), and validation of performance improvement projects (PIPs).

On September 23, 2018, 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 about the EQR process and the desk materials CCME requested.

The review consists of two segments. The first is a desk review of materials and documents received from Select Health on October 8, 2018 and reviewed in the offices of CCME (see Attachment 1). These items focus on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management programs. CCME's desk review also includes a review of credentialing, grievance, utilization, case management (CM), and appeal files.

The second segment is an Onsite review conducted November 8, 2018 and November 9, 2018 at the Select Health office located in Charleston, SC. The Onsite visit focuses on areas not covered in the desk review or items needing clarification. See Attachment 2 for a list of items requested for the Onsite visit. Onsite activities include an entrance conference, interviews with Select Health administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The findings from the EQR are summarized below and based on the regulations set forth in title *42 of the Code of Federal Regulations (CFR), Part 438*, and the contract requirements between Select Health and SCDHHS. Strengths, weaknesses and recommendations are identified, where applicable. Areas of review are identified as meeting a standard (Met), acceptable but needing improvement (Partially Met), failing a standard (Not Met), Not Applicable, or Not Evaluated, and are recorded in the tabular spreadsheet (Attachment 4).

A. Administration

The administration review of Select Health focuses on policies and procedures, staffing, information systems, compliance, program integrity, and confidentiality.

Select Health is a subsidiary of AmeriHealth Caritas, and First Choice is Select Health's Medicaid health plan in South Carolina. Courtnay Thompson is the Market President and is responsible for the general oversight, administration, and implementation of the health plan. Dr. Kirt Caton, Medical Director and Market Chief Medical Officer (CMO), is board certified in family medicine and provides medical leadership for the health plan. Dr. Roger Beardmore, Behavioral Health Medical Director, is a South Carolina-licensed psychologist. Select Health's organizational chart revealed several vacancies. During Onsite discussion, CCME confirmed that several of the vacancies were filled since the organizational chart was submitted, and recruitment/hiring activities are underway to fill the remaining vacancies.

The plan reviews policies at least annually and makes revisions as needed. Staff members can access policies via a shared network drive and iNSIGHT, a local intranet site. Department heads are responsible for ensuring all applicable staff review new and revised policies.

Deonys de Cardenas, Director of Compliance/Compliance Officer, oversees and manages the Compliance Program. Elizabeth Saragusa, Program Integrity Coordinator, coordinates fraud, waste, and abuse (FWA) activities with SCDHHS' Program Integrity/Surveillance Utilization Review Division.

The Select Health *Compliance Program and Program Integrity Plan*, along with associated policies, define requirements and guide staff executing Compliance and Program Integrity functions. Select Health has an established Code of Conduct and Ethics (Code) that provides comprehensive information and guidance about standards of ethical behavior and compliance with federal and state laws. The Code applies to all staff, including the Board of Directors (BOD), officers, contingent staff, subcontractors, and vendors. The plan makes the Code available at the time of appointment or hire and annually, thereafter. Select Health enforces compliance and ethical standards through well-publicized disciplinary guidelines that reflect clear, specific disciplinary policies and consequences for violations of the Code. A "no retaliation" policy is also in place and enforced. Annual training is provided to reinforce compliance with the Code of Conduct and Ethics.

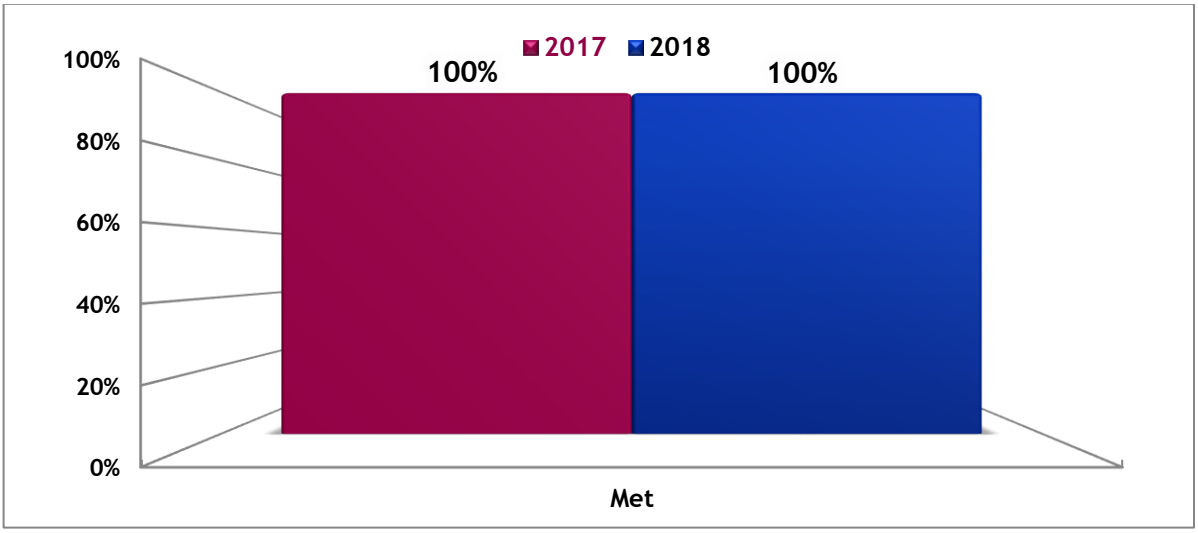
The Select Health Compliance Committee meets routinely and monitors the Compliance Program. Activities include receiving reviews and findings from the Compliance Officer, making recommendations for the *Annual Compliance and Privacy Work Plan*, and providing guidance for compliance initiatives and activities. Committee membership is appropriate and documented consistently across all information sources.

Internal standards for timeliness of claims processing include 90% of clean claims paid in 30 days of receipt, and 99% of all claims paid within 90 days of receipt. Supervisors

review claim inventory reports daily to ensure the plan meets claims processing requirements. The MCO's infrastructure can receive electronic files, and an Electronic Data Interchange (EDI) process verifies electronic claim data conforms to appropriate compliance standards. Select Health processes membership files daily, and automatically updates any modifications to demographic information, category of assistance, change of medical assistance, eligibility, new enrollment, disenrollment, or PCP change. Additionally, processes are in place to verify demographics and the accuracy of enrollment data routinely. The Select Health Disaster Recovery (DR) plan addresses all the areas needed to respond to disasters of varying magnitudes, includes guides to determine disaster severity, and checklists to review DR activities. During the most recent DR plan testing, all recovery objectives were achieved.

As illustrated in *Figure 2, Administration Findings*, Select Health received "Met" scores for 100% of the standards in the Administration section.

Figure 2: Administration Findings



Strengths

- Select Health filled several vacant positions recently and is in the process of filling the remaining vacancies.
- Detailed disaster recovery process documentation is in place.
- A recent risk assessment indicates Select Health information systems infrastructure scored highly.

Weaknesses

- Select Health's organizational chart reflects a total of 53 Customer Service Representatives (CSRs). The organizational chart indicates three of the CSRs report to Margaret Johnson. The organizational chart does not clearly indicate to whom the remaining 50 CSRs report.
- The *Quality Assessment and Performance Improvement Program Description* defines roles and responsibilities of the Regional CMO on page 19 but contains no information about the Market CMO.
- The contractually-required position of Interagency Liaison is not indicated on the organizational chart.

Recommendations

- Revise the organizational chart to clearly indicate to whom all CSRs report.
- Revise page 19 of the *Quality Assessment and Performance Improvement Program Description* to refer to the Market CMO rather than the Regional CMO.
- Ensure all contractually-required positions are reflected in the organizational chart.

B. Provider Services

CCME reviewed Select Health policies and procedures, provider agreement, provider training and educational materials, provider network information, credentialing and recredentialing files, and practice guidelines as part of its EQR of provider services. Dr. Kirt Caton, Market CMO, chairs the Credentialing Committee. Additional voting members include a Behavioral Health Medical Director, Regional Utilization Management (UM) Medical Director, a network Certified Registered Nurse Practitioner, and four network physicians with specialties in pediatrics, family practice, and orthopedic surgery. Select Health also utilizes three additional members (two Medical Directors and an obstetrics (OB)/gynecology (GYN) network physician) ad hoc and they vote only when attending a meeting. The committee meets monthly, or at a minimum of 11 times a year. A quorum is established upon attendance of at least 50% of voting members, and the committee chair votes only in the event of a tie. A review of committee meeting minutes reflects quorums met and active participation by committee members.

The *Credentialing Program 2018*, Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, and several additional policies address provider credentialing and recredentialing. CCME suggests that Select Health update Policy CR.100.SC to address how the plan considers provider performance during recredentialing. The credentialing files contain appropriate documentation; however, the majority of recredentialing files contain *Ownership Disclosure Forms* that are outdated. Files reflect forms signed in years 2010, 2013, 2015, 2016, and 2017. The form signed in

2010 was *Form 1513* instead of the required *1514 Form*. CCME confirmed during the Onsite discussion that while Select Health has a separate process to collect and update *Ownership Disclosure Forms*, the recredentialing process never included pursuing or reviewing updated forms.

Policies define network accessibility, provider availability standards, and procedures for assessing the network. Select Health conducts telephonic surveys to assess provider adherence to appointment standards for Primary Care Physicians (PCPs), high-volume/high-impact specialists, and behavioral health providers; however, this process is not addressed in the Accessibility of Services Policy or the Accessibility of Behavioral Healthcare Services Policy. Results of the telephonic surveys show the 95% goal for existing patients for Emergent, Urgent, and Routine care as met. New patient access to primary care is trending lower than desired. The High Volume and High Impact Specialties were not met for many of the specialists evaluated, in particular for new patients. Prescriber and Non-Prescriber accessibility results fell below the 95% compliance goal for all behavioral health access standards.

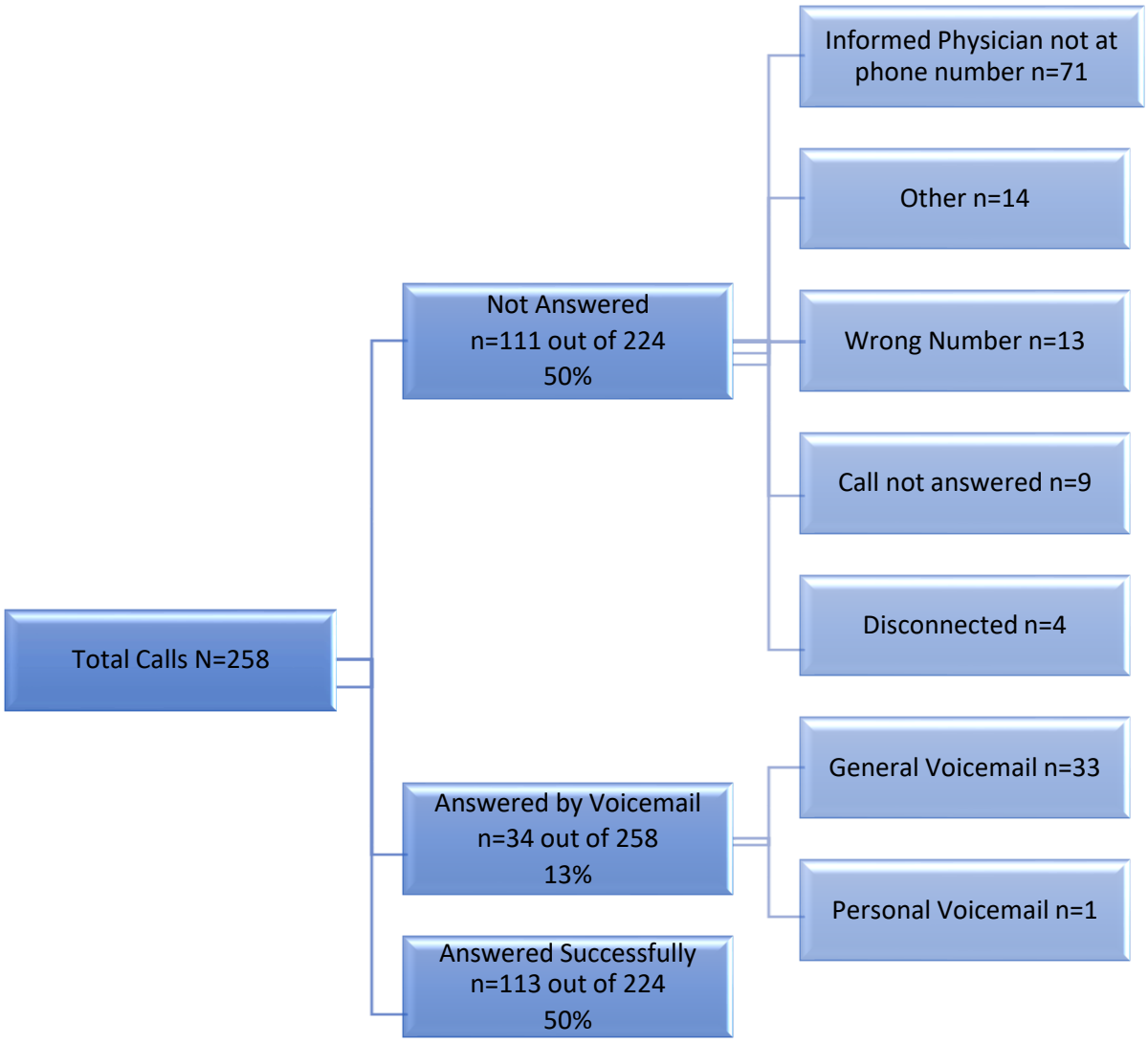
Several documents in the desk materials support the adoption of clinical practice guidelines; however, CCME noted inconsistencies between documents and the website regarding approved clinical practice guidelines.

Provider Access and Availability Study

As part of the annual EQR process for Select Health, CCME performed a provider access study focused on primary care providers. A list of current providers was given to CCME by Select Health, from which a population of 2,296 unique PCPs was found. CCME randomly selected a sample of 258 providers from this population for the access study. Providers were asked a series of questions about member access to contracted providers.

During the Telephonic Provider Access Study, calls were successfully answered 50% of the time (113 out of 224) when omitting calls answered by personal or general voicemail messaging services (see *Figure 3*). During the Onsite visit, CCME found Select Health has a Provider Network Management workgroup tasked with ongoing assessment of provider access. In addition, routine data updates are made when Account Executives visit provider offices and when change requests are received directly from a provider.

Figure 3: Provider Access Study Results



When compared to 2017 results of 55%, the 2018 study has a non-statistically significant decrease in successful calls (p=.242). (See *Table 4*)

Table 4: Provider Access Study Results for Current and Previous Review Cycle

	Sample Size	Answer Rate	Fisher's exact p-value
2017 Review	291	55%	.242
2018 Review	258	50%	

For calls not answered successfully (n=111 calls), 71 (64%) were unsuccessful because the provider was not at the office or phone number listed. Of 113 successful calls, 102 (90%) of the providers indicated they accept Select Health, although one (<1%) indicated that this occurred only under certain conditions. Of the 101 providers who accept Select Health, 77 (76%) responded they are accepting new Medicaid patients.

Regarding a screening process for new patients, 33 (44%) of the 75 providers who responded to the item indicated that an application or prescreen was necessary for new patients. Of those 33, five (15%) indicated that an application must be completed, whereas 11 (33%) require a review of medical records before accepting a new patient, and nine (27%) required both. When the office was asked about the next available routine appointment, 52 (76%) of the 68 responses met contact requirements.

Figure 4, Provider Services Findings shows that 94% of the standards in Provider Services received a "Met" score. *Table 5, Provider Services Comparative Data*, highlights standards showing a change in score from 2017 to 2018.

Figure 4: Provider Services Findings

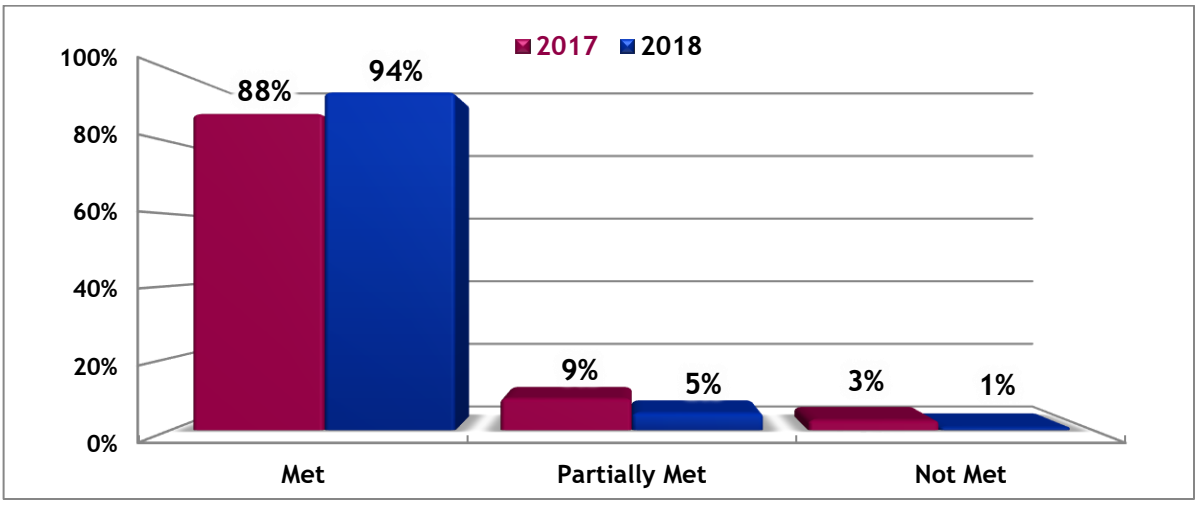


Table 5: Provider Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	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	Partially Met	Met
	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	Partially Met	Met
	Credentialing: Query of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Partially Met	Met
	Credentialing: Query of Social Security Administration's Death Master File (SSDMF)	Not Met	Met
	Recredentialing: Requery of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List	Partially Met	Met
	Recredentialing: Query of Social Security Administration's Death Master File (SSDMF)	Not Met	Met
	Recredentialing: Ownership Disclosure Form	Met	Partially Met
	Review of practitioner profiling activities	Met	Partially Met
	The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Partially Met	Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Met

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Credentialing and Recredentialing	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Partially Met	Met
Adequacy of the Provider Network	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met
	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Not Met
Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services	The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Select Health uses a comprehensive presentation for new provider orientation that is conducted by Account Executives. Additional training is provided through regional training sessions and webinars.
- The Select Health website is user-friendly and contains a wealth of provider resource information such as the *Provider Manual*, practice guidelines, newsletters, training and education, etc.

Weaknesses

- The majority of the recredentialing files reviewed contained outdated *Ownership Disclosure Forms*. The recredentialing process never included pursuing or reviewing updated forms.
- Policy CR.100 SC, Health Care Professional Credentialing and Recredentialing does not address how Select Health considers provider performance during recredentialing.

- Policy NM 159.203, Accessibility of Services, and Policy NM 159.306, Accessibility of Behavioral Healthcare Services do not address Select Health's process for conducting telephone access studies for provider adherence to appointment standards.
- The *Telephonic Provider Access Study* success rate declined from 55% in 2017 to 50% in 2018.
- Several documents in the desk materials support the adoption of clinical practice guidelines; however, there are inconsistencies as follows:
  - Memo from Dr. Kirt Caton to the Quality Improvement Committee on September 27th, 2018 lists titles of clinical practice guidelines and several relating to Asthma were not found on the website such as Asthma Children 0-4 years, Asthma Children 5-11, Asthma General Principles, and Asthma Youth 12 Years and Older and Adults.
  - The Clinical Practice Guidelines listed on pages 35-36 of the 2018 Quality Assessment Performance Improvement (QAPI) Program Description do not match the Clinical Practice Guidelines listed in the Corporate Clinical Guidelines document received in the desk materials; some guidelines are different, and some web-links are outdated or do not work.
- Coordination of care is monitored when the member is in CM, but CCME finds no evidence that monitoring occurs for members who are not in CM.

Quality Improvement Plans

- Ensure the recredentialing process includes collecting updated *Ownership Disclosure Forms*.
- Update Policy CR.100 SC, Health Care Professional Credentialing and Recredentialing to include the plan's process for considering provider performance during recredentialing.
- Update Policy NM 159.203, Accessibility of Services and Policy NM 159.306, Accessibility of Behavioral Healthcare Services to include the plan's process for conducting telephone access studies that assess provider adherence to appointment standards.
- Update provider contact information more frequently to maintain accurate contact information.
- Ensure adopted clinical practice guidelines are consistent between documents and the website, and that all web-links are usable.

Recommendations

- Follow the process outlined in Policy QI 154.011, Monitoring Continuity and Coordination of Care for monitoring continuity and coordination of care.

C. Member Services

The review of Member Services encompasses member rights; member education about the health plan, benefits, and services; enrollment and disenrollment; preventive health and chronic disease management education; the *Member Satisfaction Survey*; and grievances.

Select Health's Member Services Call Center is located in South Carolina, and Select Health maintains a toll-free telephone number and Text Telephone (TTY) services for callers. Member Services staff are available Monday through Friday from 8:00 a.m. to 9:00 p.m., as well as Saturday and Sunday from 8:00 a.m. to 6:00 p.m. After normal business hours, callers can leave a confidential voice message and have the option to speak with the Nurse Help Line, available 24 hours a day, seven days a week. Member Services staff respond to voice messages within one business day of receipt.

To provide education about the health plan, Select Health mails a packet of information to new members within 30 calendar days of receipt of enrollment data from the South Carolina Department of Health and Human Services (SCDHHS). These packets contain a *Member Handbook*, *Co-payment Reference Guide*, and a *Quick-Start Guide*. In addition, new member orientation calls are conducted by CSRs within two weeks of enrollment to provide a scripted orientation to the health plan, assist members with selection of a PCP, and ensure members understand the rights to which they are entitled. Select Health maintains a *Member Handbook List of Changes* on its website.

The *Member Handbook* did not include an explanation of post-stabilization care, even though the list of member rights in the *Member Handbook* stated members have the right to receive detailed information about emergency coverage and post-stabilization services. Additional issues noted in the Member Handbook include lack of information about how members are notified of significant changes in the benefits package (services, benefits, and providers) and incorrect information about enrolling a newborn in a different health plan.

Member rights and responsibilities are defined in the *Member Handbook* and on the website. The packet of information sent to new members describes how members can view their rights and responsibilities online or receive a paper copy, and instructions for obtaining a copy of rights and responsibilities are published in the member newsletter annually.

Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services is included in the *Member Handbook*. When searching for EPSDT information on the First Choice website, CCME noted the reader is referred to Pennsylvania's *EPSDT Periodicity Schedule and Coding Matrix*; however, the *SCDHHS Contract*, *Section 4.2.10.2*

and the SCDHHS Medicaid website indicate the *Bright Futures/American Academy of Pediatrics (AAP) Medical Periodicity Schedule* should be followed.

Select Health has engaged Morpace, a certified Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey vendor, to conduct annual *Member Satisfaction Surveys*. For both the Adult and Child surveys, response rates for 2018 show no improvement over the 2017 response rates, remaining at 21% and 24% respectively. The Child Medicaid, Children with Chronic Conditions (CCC) total sample response rate for 2018 is 26%, which represents a slight increase from 2017. All response rates fall below the National committee for Quality Assurance (NCQA) target response rate of 40%. CCME encourages Select Health to continue working with the vendor to improve response rates.

CCME reviewed documentation of grievance processes and requirements in policy, the *Member Handbook*, the *Provider Manual*, and on First Choice's website. The *Provider Manual* documentation about how to file a grievance is incomplete. Also, the *Provider Manual* references a five business-day grievance response timeframe and does not include information about extensions of grievance resolution timeframes in the grievance section of the manual. The grievance files reflect timely determinations and notifications of grievance resolutions; however, issues were identified in the contents of grievance resolution letters, including:

- Pre-formulated, standard verbiage that does not correspond to the investigation and resolution documented in the file.
- Insufficient information for the member to understand how the grievance was resolved.

As noted in *Figure 5: Member Services Findings*, Select Health achieved "Met" scores for 88% of the Member Services standards for 2018. Twelve percent of the standards are scored as "Partially Met." The figure compares the scoring percentages for the 2018 and 2017 reviews for the Member Services section.

Figure 5: Member Services Findings

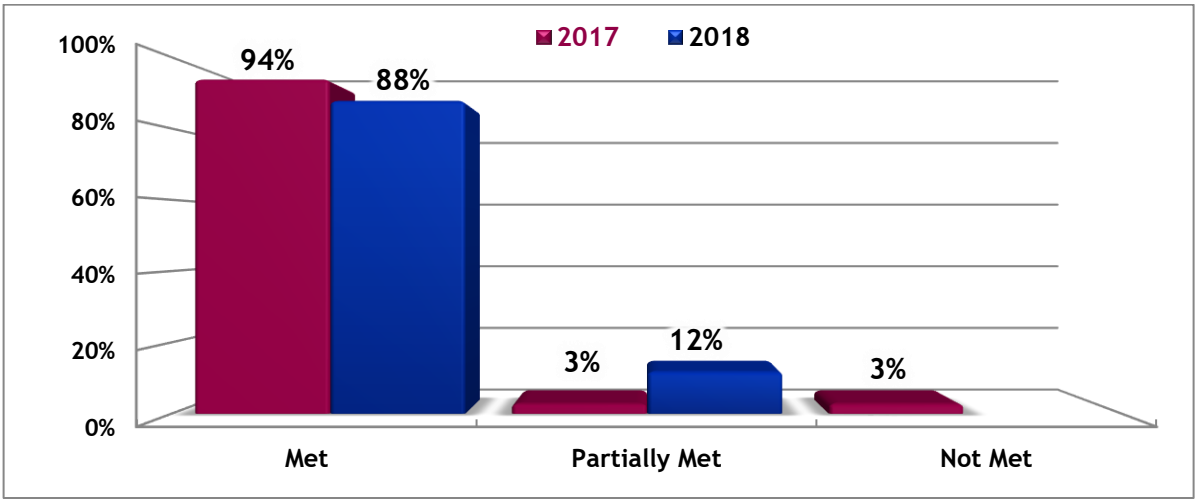


Table 6: Member Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Member MCO Program Education	Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information	Met	Partially Met
	Member program education materials are written in a clear and understandable manner and meet contract requirements	Met	Partially Met
Grievances	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 the procedure for filing and handling a grievance	Met	Partially Met
	Timeliness guidelines for resolution of the grievance	Met	Partially Met
	The MCO applies grievance policies and procedures as formulated	Not Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Grievance files demonstrate that provider site visits are conducted each time there is a complaint about the office cleanliness, etc.
- The *Member Handbook* includes a comprehensive, easily understood explanation of Advance Directives and provides instructions for members to obtain more information or forms needed to implement an Advance Directive.

Weaknesses

- The "Member Rights" section of the *Member Handbook* (page 24, item 16) states it is a member's right to receive detailed information about emergency and after-hours coverage, including "what constitutes an emergency medical condition, emergency services and post-stabilization services." No information about or explanation of post-stabilization care is found elsewhere in the *Member Handbook*.
- The *Member Handbook* list of member rights indicates members have the right to receive notice of significant changes in the benefits package (services, benefits, and providers) at least 30 days before the intended effective date of the change. The *Member Handbook* does not specify how this notification is provided.
- The *Member Handbook*, page 30, provides misleading information about enrolling newborns into another health plan.
- The following issues were noted regarding EPSDT information on the First Choice website[1]:
  - The reader is referred to Pennsylvania's *EPSDT Periodicity Schedule and Coding Matrix*; however, the *SCDHHS Contract, Section 4.2.10.2*, requires using the *Bright Futures/AAP Medical Periodicity Schedule*.
  - Missing hyperlinks are noted in three locations on the same webpage.
- Policy COM 220.100, Collateral Approval – South Carolina Department of Health and Human Services defines the required reading level of member materials but does not define the method used to determine member material reading levels.
- For both the Adult and Child CAHPS surveys, response rates for the 2018 surveys are the same as for the 2017 surveys and fall below the NCQA target of 40%.
- The *Provider Manual*, page 50, states grievances can be filed by calling member services but does not include that grievances can also be filed in writing or how to complete a written filing.
- Issues with documentation of grievance resolution timeframes include:

[1] https://www.selecthealthofsc.com/preventive-care/provider/awc/educate-members.aspx

  - Page 50 of the *Provider Manual* states the grievance resolution timeframe is 90 calendar days from the day Select Health receives the grievance; however, the next paragraph states Select Health is "required to investigate grievances not related to the physical condition of the office and respond to the member within five business days."
  - Information about extensions of grievance resolution timeframes is not found within the "Member Grievances" section (pages 50-51) of the *Provider Manual*. Instead, it is included under a separate heading "Extension of Grievance and Appeal Resolution Time Frames" on pages 37-38 of the *Provider Manual*.
- Issues identified in grievance files are related to information in the resolution letters. These include:
  - Use of pre-formulated, standard verbiage that does not always apply to the resolution of the grievance and that is not corroborated by documentation found in the file.
  - Lack of sufficient information for the member to understand how the grievance was resolved.

Quality Improvement Plans

- Revise the *Member Handbook* to include member-appropriate information explaining post-stabilization care and coverage.
- Correct page 30 of the *Member Handbook* to remove the requirement that the member must change plans to enroll a newborn in a different plan.
- Revise the website to refer the reader to the *Bright Futures/AAP Medical Periodicity Schedule* and correct missing hyperlinks.
- Update page 50 of the *Provider Manual* to include all methods of filing grievances.
- Remove the incorrect information that states Select Health must respond to member grievances within five business days from pages 50-51 of the *Provider Manual*.
- Avoid using pre-formulated, standard verbiage that does not apply or does not correspond to the plan's notes documenting the resolution activities in grievance resolution letters.
- Ensure grievance resolution letters contain enough information for the member to understand what occurred (when possible) to resolve the grievance.

Recommendations

- Update the *Member Handbook* to include how members are notified of a significant change in services, benefits, and providers.

- Include the method used to determine readability of member materials in Policy COM 220.100, Collateral Approval – South Carolina Department of Health and Human Services.
- Continue working with vendors to increase CAHPS survey response rates.
- Include information about extensions of grievance resolution timeframes in the "Member Grievances" section of the *Provider Manual*.

D. Quality Improvement

As part of its External Quality Review, CCME reviewed the *Quality Assessment Performance Improvement (QAPI) 2018 Program Description*, committee structure and minutes, PMs, PIPs, and the QAPI program evaluation. The Select Health *QAPI Program Description* describes the quality improvement program structure, function, scope, and goals defined by the health plan. The BOD provides strategic direction and ultimate authority and responsibility for the QI Program and approves the Program Description annually. The BOD delegates the operational responsibility for the program to Select Health's Market President, Courtnay Thompson, and to the Quality Assessment Performance Improvement Committee (QAPIC). The QAPIC directs and reviews the Quality Improvement (QI), UM, and the Integrated Health Care Management activities.

Select Health evaluates the effectiveness of its QI Program annually. For this review, the health plan provided the *Quality Assessment Performance Improvement 2017 Program Evaluation*. This report documents a high-level assessment of the of the results of the QI activities conducted in 2017. In some of the analysis of the HEDIS measures there is confusion regarding the reported rate for the calendar year, or the analysis indicates there is a reduction in the rate when in fact there is an increase in the reported rate. The report identifies barriers, interventions, and improvement opportunities.

Performance Measure Validation

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

Select Health uses Inovalon, a certified software organization, for calculating HEDIS rates. Rates are audited by HealthcareDataCompany, LLC. The comparison from the previous to the current year reveal a strong increase in Body Mass Index (BMI) Percentile Documentation and Follow-Up Care for Children Prescribed ADHD Medication Continuation and Maintenance. The most problematic is Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) for 1- to 5- year-olds, which decreased 20%. The 2018 rate, the 2017 rate, and the change in rate are presented in *Table 7: HEDIS Performance Measure Data*.

Table 7: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	86.31%	86.47%	0.16%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	71.53%	83.46%	11.93%
Counseling for Nutrition	59.03%	62.47%	3.44%
Counseling for Physical Activity	56.25%	59.75%	3.50%
Childhood Immunization Status (cis)			
DTaP	75.23%	79.32%	4.09%
IPV	88.19%	90.51%	2.32%
MMR	90.05%	92.21%	2.16%
HiB	84.26%	88.56%	4.30%
Hepatitis B	85.42%	88.56%	3.14%
VZV	90.05%	91.97%	1.92%
Pneumococcal Conjugate	78.94%	79.81%	0.87%
Hepatitis A	88.66%	88.81%	0.15%
Rotavirus	78.24%	77.37%	-0.87%
Influenza	42.82%	45.26%	2.44%
Combination #2	70.14%	75.91%	5.77%
Combination #3	68.29%	73.72%	5.43%
Combination #4	67.59%	72.02%	4.43%
Combination #5	63.19%	68.37%	5.18%
Combination #6	38.19%	39.17%	0.98%
Combination #7	62.50%	67.40%	4.90%
Combination #8	38.19%	38.69%	0.50%
Combination #9	36.34%	37.47%	1.13%
Combination #10	36.34%	37.47%	1.13%
Immunizations for Adolescents (ima)			
Meningococcal	74.54%	74.70%	0.16%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Tdap/Td	88.43%	88.56%	0.13%
Combination #1	72.69%	73.97%	1.28%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	26.16%	31.14%	4.98%
Lead Screening in Children (lsc)	75.38%	71.88%	-3.50%
Breast Cancer Screening (bcs)	61.85%	62.20%	0.35%
Cervical Cancer Screening (ccs)	66.50%	71.16%	4.66%
Chlamydia Screening in Women (chl)			
16-20 Years	51.98%	54.09%	2.11%
21-24 Years	63.23%	63.26%	0.03%
Total	55.32%	56.70%	1.38%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	79.30%	83.37%	4.07%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	32.90%	30.29%	-2.61%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	64.55%	65.22%	0.67%
Bronchodilator	80.57%	79.63%	-0.94%
Medication Management for People with Asthma (mma)			
5-11 Years - Medication Compliance 50%	63.66%	65.77%	2.11%
5-11 Years - Medication Compliance 75%	37.05%	38.48%	1.43%
12-18 Years - Medication Compliance 50%	60.27%	60.19%	-0.08%
12-18 Years - Medication Compliance 75%	33.94%	35.86%	1.92%
19-50 Years - Medication Compliance 50%	59.96%	60.20%	0.24%
19-50 Years - Medication Compliance 75%	37.24%	38.10%	0.86%
51-64 Years - Medication Compliance 50%	70.83%	73.24%	2.41%
51-64 Years - Medication Compliance 75%	52.78%	47.89%	-4.89%
Total - Medication Compliance 50%	62.33%	63.43%	1.10%
Total - Medication Compliance 75%	36.35%	37.70%	1.35%
Asthma Medication Ratio (amr)			
5-11 Years	69.20%	69.64%	0.44%
12-18 Years	61.30%	61.08%	-0.22%
19-50 Years	53.30%	54.35%	1.05%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
51-64 Years	54.12%	54.68%	0.56%
Total	64.50%	64.58%	0.08%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	50.69%	60.58%	9.89%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	78.57%	79.12%	0.55%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	79.33%	77.75%	-1.58%
Statin Adherence 80% - 21-75 years (Male)	63.38%	64.65%	1.27%
Received Statin Therapy - 40-75 years (Female)	75.73%	76.66%	0.93%
Statin Adherence 80% - 40-75 years (Female)	62.37%	59.86%	-2.51%
Received Statin Therapy - Total	77.48%	77.21%	-0.27%
Statin Adherence 80% - Total	62.87%	62.29%	-0.58%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	92.37%	88.87%	-3.50%
HbA1c Poor Control (>9.0%)	47.93%	46.64%	-1.29%
HbA1c Control (<8.0%)	41.79%	45.23%	3.44%
HbA1c Control (<7.0%)	32.08%	30.66%	-1.42%
Eye Exam (Retinal) Performed	56.72%	56.89%	0.17%
Medical Attention for Nephropathy	92.21%	92.76%	0.55%
Blood Pressure Control (<140/90 mm Hg)	52.07%	59.54%	7.47%
Statin Therapy for Patients with Diabetes (spd)			
Received Statin Therapy	58.18%	58.81%	0.63%
Statin Adherence 80%	53.03%	56.45%	3.42%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	77.22%	70.21%	-7.01%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Effective Acute Phase Treatment	49.76%	50.58%	0.82%
Effective Continuation Phase Treatment	33.74%	36.40%	2.66%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	43.14%	42.10%	-1.04%
Continuation and Maintenance Phase	28.79%	53.75%	24.96%
Follow-Up After Emergency Department Visit for Mental Illness (fuh)			
30-Day Follow-Up		64.83%	NA
7-Day Follow-Up		40.89%	NA
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
30-Day Follow-Up	60.05%	64.11%	4.06%
7-Day Follow-Up	44.55%	45.20%	0.65%
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: 13-17 Years		14.29%	NA
7-Day Follow-Up: 13-17 Years		9.82%	NA
30-Day Follow-Up: 18+ Years		14.98%	NA
7-Day Follow-Up: 18+ Years		9.60%	NA
30-Day Follow-Up: Total		14.89%	NA
7-Day Follow-Up: Total		9.63%	NA
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	77.20%	77.27%	0.07%
Diabetes Monitoring for People with Diabetes and Schizophrenia (smd)	66.20%	66.98%	0.78%
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (smc)	70.59%	62.96%	-7.63%
Adherence to Antipsychotic Medications for Individual with Schizophrenia (saa)	68.29%	65.16%	-3.13%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
1-5 Years	36.11%	36.67%	0.56%
6-11 Years	20.66%	29.10%	8.44%
12-17 Years	24.74%	30.79%	6.05%
Total	23.56%	30.33%	6.77%
Effectiveness of Care: Medication Management			

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	88.23%	88.51%	0.28%
Diuretics	88.03%	88.50%	0.47%
Total	87.85%	88.50%	0.65%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.66%	1.11%	-0.55%
Appropriate Treatment for Children with URI (uri)	84.29%	85.06%	0.77%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	22.94%	23.08%	0.14%
Use of Imaging Studies for Low Back Pain (lbp)	76.15%	74.10%	-2.05%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
1-5 Years	0.00%	0.00%	0.00%
6-11 Years	0.23%	0.00%	-0.23%
12-17 Years	0.28%	0.61%	0.33%
Total	0.25%	0.47%	0.22%
Use of Opioids and High Dosage (uod)		53.50	NA
Use of Opioids from Multiple Providers (uop)			
Multiple Prescribers		245.66	NA
Multiple Pharmacies		152.78	NA
Multiple Prescribers and Multiple Pharmacies		78.63	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	**80.67%**	**79.48%**	**-1.19%**
45-64 Years	**89.81%**	**89.26%**	**-0.55%**
Total	**82.83%**	**81.79%**	**-1.04%**
Children and Adolescents' Access to Primary Care Practitioners (cap)			
12-24 Months	97.27%	**97.03%**	**-0.24%**
25 Months - 6 Years	88.29%	88.37%	0.08%
7-11 Years	91.75%	91.58%	-0.17%

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
12-19 Years	90.28%	90.23%	-0.05%
Initiation and Engagement of AOD Abuse or Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years		38.84%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years		26.45%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years		63.64%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years		45.45%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years		39.23%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years		25.68%	NA
Total: Initiation of AOD Treatment: 13-17 Years		38.79%	NA
Total: Engagement of AOD Treatment: 13-17 Years		24.63%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years		38.67%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years		12.81%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years		51.44%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years		22.97%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years		36.26%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years		13.03%	NA
Total: Initiation of AOD Treatment: 18+ Years		38.59%	NA
Total: Engagement of AOD Treatment: 18+ Years		13.83%	NA
Alcohol abuse or dependence: Initiation of AOD Treatment: Total		38.69%	NA
Alcohol abuse or dependence: Engagement of AOD Treatment: Total		14.04%	NA
Opioid abuse or dependence: Initiation of AOD Treatment: Total		51.80%	NA
Opioid abuse or dependence: Engagement of AOD Treatment: Total		23.63%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: Total		36.92%	NA
Other drug abuse or dependence: Engagement of AOD Treatment: Total		15.84%	NA
Total: Initiation of AOD Treatment: Total		38.62%	NA
Total: Engagement of AOD Treatment: Total		15.56%	NA

MEASURE/DATA ELEMENT	CY 2016	CY 2017	PERCENTAGE POINT DIFFERENCE
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	89.94%	90.73%	0.79%
Postpartum Care	75.30%	78.27%	2.97%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-5 Years	60.00%	40.00%	-20.00%
6-11 Years	67.01%	64.45%	-2.56%
12-17 Years	64.19%	56.01%	-8.18%
Total	65.05%	58.37%	-6.68%
Utilization			
Frequency of Ongoing Prenatal Care (fpc)			
<21 Percent	5.18%	NA	NA
21-40 Percent	1.83%	NA	NA
41-60 Percent	6.71%	NA	NA
61-80 Percent	8.23%	NA	NA
81+ Percent	78.05%	NA	NA
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%

Performance Improvement Project Validation

Validation of the PIPs is in accordance with the CMS protocol *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:

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

In 2017, the plan submitted and CCME validated two new projects. They were: *Diabetes Outcomes Measures* and *Follow-up After Hospitalization for Mental Health Within 7 and 30 Days After Discharge*. Both projects contained baseline data only, and the primary issues were documentation of personnel and data analysis matching the data analysis plan. For this review, those same PIPs were validated. *Table 8, Performance Improvement Project Validation Scores* provides an overview of each project's validation score.

TABLE 8: Performance Improvement Project Validation Scores

PROJECT	2017 VALIDATION SCORE	2018 VALIDATION SCORE
Diabetes Outcomes Measures: Clinical	96/103= 93% High Confidence in Reported Results	110/111=99% High Confidence in Reported Results
Follow-up After Hospitalization for Mental Health Within 7 and 30 Calendar Days After Discharge: Non-Clinical	84/96= 88% Confidence in Reported Results	91/91=100% High Confidence in Reported Results

Both projects scored within the High Confidence range with only minor errors in the Diabetes PIP. There were issues regarding the p-values. In the results section, the actual p-value that is a result of the comparison should be documented. It should be p=.652 for the first measure, p=.230 for HbA1C<8, and p=.009 for controlling BP <140/90. Instead of <.00001, the calculated p-value should be presented on pages 10,11, and 12 of the project documents. Recommendations for the Diabetes PIP are displayed in *Table 9, Performance Improvement Project Errors and Recommendations*.

TABLE 9: Performance Improvement Project Errors and Recommendations

Section	Reasoning	Recommendation
Diabetes Outcomes Measures		

Section	Reasoning	Recommendation
Is there any statistical evidence that any observed performance improvement is true improvement?	Statistical significance was demonstrated using z-tests, but the p-values are not properly documented.	The actual p-value that is a result of the comparison should be documented. It should be was p=.652 for the first measure, p=.230 for HbA1C<8, and p=.009 for controlling BP <140/90I them. Instead of <.00001, the calculated p-value should be presented.

Details of the validation of the PMs and PIPs are found in the *CCME EQR Validation Worksheets, Attachment 3*.

Figure 6, Quality Improvement Findings indicates that 100% of the standards receive a "Met" score.

Figure 6: Quality Improvement Findings

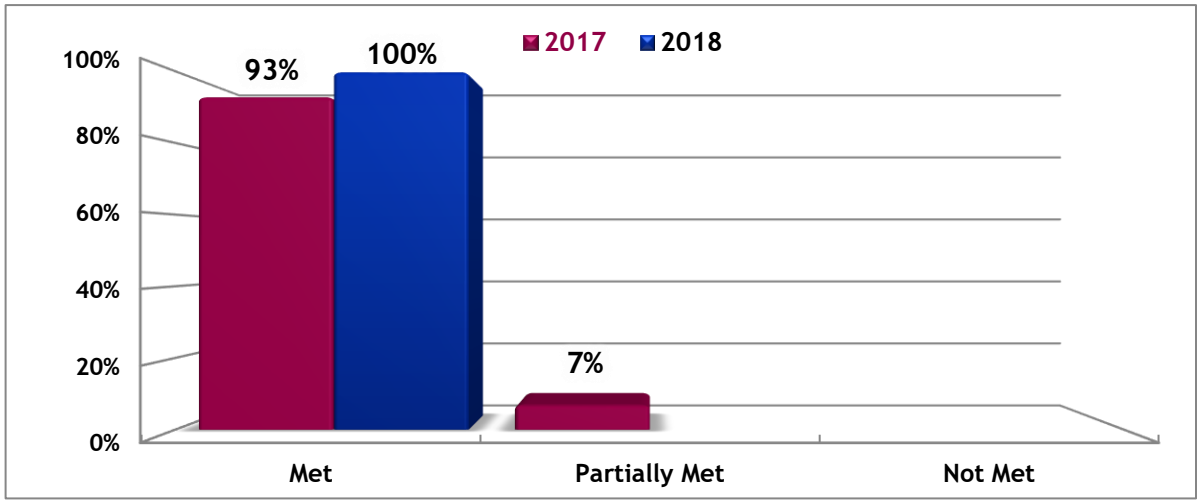


TABLE 10: Quality Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Quality Improvement Projects	The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Weaknesses

- CCME notes a few issues identified in the 2018 Program Description that appear incorrect or confusing. These include:
  - Page 4 indicates this is the *2017 QAPI Program Description*.
  - Page 9 states the QAPI work plan includes planned monitoring or previously identified issues. This is not found in the work plan.
  - The Committee Structure on page 10 included the Culturally and Linguistically Appropriate Services (CLAS) committee. Onsite Select staff indicated this committee was no longer a committee under Quality.
  - The designated physician providing clinical expertise for the Quality program is listed as the Regional Chief Medical Officer on page 19; however, the Market CMO, Dr. Caton, is responsible for providing clinical oversight.
  - Monitoring Continuity and Coordination of Care is listed as one of the QI activities on page 29. The result of this monitoring as described on page 29 is not present.
- The QI Program Description includes the voting members from the Quality of Clinical Care (QCC)Committee as the network providers and the health plan's Medical Directors. The voting members listed in the committee charter and on the meeting minutes are inconsistent with the QI Program Description.
- According to the QI Program Description, the QCC meets bi-monthly or a minimum of five times per year; minutes for the QCC were not provided for all meetings.
- The *Diabetes Outcomes Measure* PIP documentation does not include actual p-values for proportion comparisons.

Recommendations

- Correct the issues identified in the *Quality Assessment and Performance Improvement 2018 Program Description*.
- Update the list of voting members in the QCC committee charter, minutes, and the QI Program Description.
- Ensure the QCC committee is meeting the required frequency as outlined in the QI Program Description and that each meeting is documented with committee minutes.
- Correct the p-values in the *Diabetes Outcomes Measure PIP* document.

E. Utilization Management

Select Health's *Integrated Utilization Management Program Description* outlines and describes the UM Program for physical and behavioral health. UM policies and procedures define how UM, medical necessity determinations, appeals, and CM services are

operationalized to provide services to members. PerformRX, the pharmacy benefit manager, coordinates decisions for drug coverage. The Market CMO, Kirt Caton, MD, provides oversight of UM activities. The Regional Pharmacy Director, Jay Messeroff, RPH, provides oversight of pharmaceutical services.

UM approval and denial files confirm timely determinations and indicate decisions are aligned with policies. Appeals are processed appropriately, and procedures are adequately communicated to staff, members, and providers.

In 2018, Select Health implemented a Population Health Management strategy that provides the framework for CM and care coordination programs using a person-centered approach. Case Management files indicate care gaps are identified and addressed consistently, and services are provided for various risk levels.

Overall, the Integrated UM Program follows requirements described in the *SCDHHS Contract* and the *Code of Federal Regulations*. CCME's review of the program reveals physical health, behavioral health, and pharmaceutical needs are considered in decision making and when providing service, utilizing a multi-disciplinary approach. CCME identified minor weaknesses and provided recommendations to address them.

Documents like the *HEDIS Utilization Dashboard* and the *2017 UM Program Evaluation* indicate the health plan monitors and analyzes under- and over-utilization of medical services as required by the contract.

As illustrated in *Figure 7*, 100% of the standards in the Utilization Management section score as "Met."

Figure 7: Utilization Management Findings

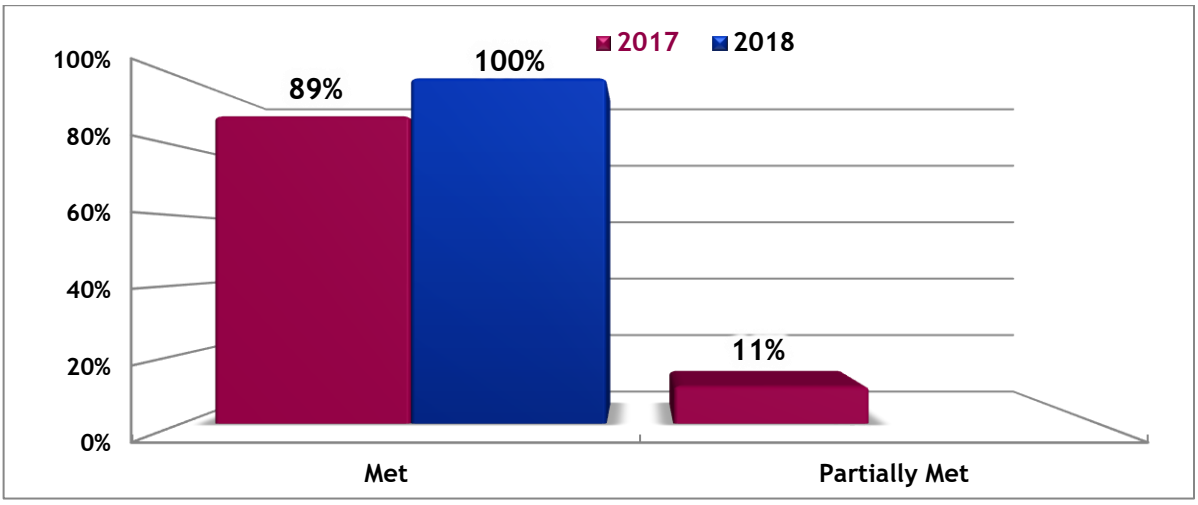


TABLE 11: Utilization Management Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 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	Partially Met	Met
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	Partially Met	Met
	Other requirements as specified in the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- Member files indicate discharge planning is discussed at the time when inpatient approval rendered.
- The *Member Appeal Request Form* is clear and easily accessible via the website.
- The link to the *Member Consent Form* in the *Provider Manual* opens to a fillable, electronic document.
- UM files reveal Medical Directors consult with UM staff about medical issues and review medical necessity denials.
- Applicable cross-referenced materials are listed in policy and procedure documents.

Weaknesses

- CCME cannot identify, in the *Member Handbook* or other documents, how members can request specialty pharmacy medications from a local pharmacy if immediate access is needed.
- The timeframe for acknowledging a member appeal is not included in the *Member Handbook* or the website.

- Appeal file #12 has discrepant receipt dates documented on the acknowledgement letter, resolution letter, and in the Episode Details.
- Appeal file #16 has inconsistent and confusing documentation regarding if the type of appeal was expedited and downgraded to standard, and it being overturned administratively due to BH timeliness to make a decision within 24 hours.
- The Integrated Health Care Management (IHCM) program is described adequately in the *Provider Manual* the Select Health website and described briefly in the *Member Handbook*.

Recommendations

- Edit the *Member Handbook* to include clear instructions for members to obtain specialty pharmacy medications from a local pharmacy if medical circumstances require more immediate access than is available from the specialty pharmacy.
- To ensure consistency between the *Provider Manual* and policies, include the requirement for acknowledgment of appeals in the *Member Handbook* and on the website.
- Ensure appeal acknowledgement letters have correct receipt dates and appeals are processed within the appropriate timeframe for the type of request.
- Include descriptions of available IHCM programs in the *Member Handbook* to be consistent with information described in the *Provider Manual* and on the website.

F. Delegation

Select Health ensures all delegation arrangements are governed by written agreements between the delegate and the plan through a *Delegation Agreement* that outlines the scope of the delegated activities, reporting responsibilities, the responsibilities of the plan, stakeholder departments, and the delegated entity performance monitoring process. Corporate Policy 277.010, Delegation Oversight defines the procedures for pre-delegation assessment of delegate capabilities along with annual oversight of delegate performance.

Select Health has delegation agreements with the following entities:

Table 12: Delegated Entities and Services

Delegated Entities	Delegated Services
Georgia Regents/AU Medical Center Greenville Hospital System	Provider credentialing, recredentialing, ongoing

Delegated Entities	Delegated Services
Health Network Solutions Mary Black Health Network Medical University of South Carolina PSG Delegated Services Regional Health Plus Roper St. Francis St. Francis Physician Services	monitoring, and decision making
NIA	UM services and provider call center functions
Orange Health Solutions dba Citra Health Solutions	Nurse triage services
BHM Healthcare Solutions, Inc.	Utilization Management

CCME received evidence of annual oversight review for all delegated entities. The plan confirmed during the Onsite review that BHM Healthcare Solutions is a new delegation and proof of the pre-delegation audit was received.

Select Health uses an NCQA tool and a South Carolina specific tool when applicable.

Credentialing and recredentialing delegated processes are addressed in Policy CR.101.SC, Delegation of Credentialing and Recredentialing. Attachment F, 2018 South Carolina/Medicaid Credentialing Requirements contains *2016 SCDHHS Contract* references, and *SCDHHS Policy and Procedure Guide* references that are outdated, and the information does not match the tool used for annual oversight which appears to be updated.

As noted in *Figure 8, Delegation Findings*, one standard out of two in the Delegation section received a "Met" score. *Table 13, Delegation Comparative Data*, highlights standards showing a change in score from 2017 to 2018.

Figure 8: Delegation Findings

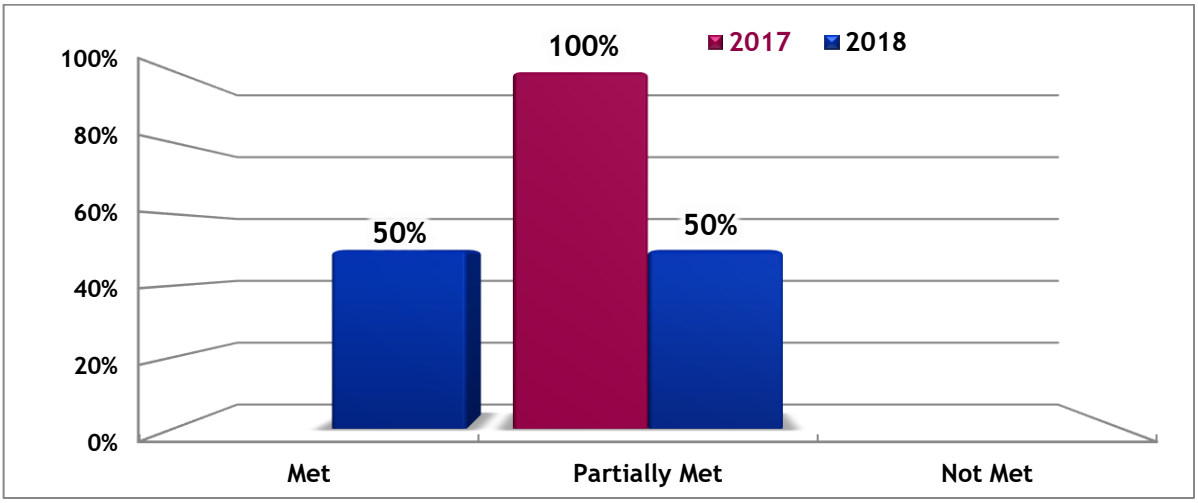


Table 13: Delegation Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Weaknesses

- Policy CR.101.SC, Attachment F, 2018 South Carolina/Medicaid Credentialing Requirements contains *2016 SCDHHS Contract* and *SCDHHS Policy and Procedure Guide* references that are outdated, and the information does not match the tool used for annual oversight which appears to be updated.

Quality Improvement Plans

- Ensure Attachment F of Policy CR.101.SC, Delegation of Credentialing and Recredentialing reflects the current *SCDHHS Contract* and *SCDHHS Policy and Procedure Guide* references.

G. State Mandated Services

Select Health ensures EPSDT services for plan members through the month of their 21st birthday and has several processes in place to notify and remind members and providers of needed EPSDT services. The plan monitors provider compliance with provision of EPSDT services and required immunizations via medical record reviews conducted by nurse reviewers. Select Health provides all core benefits specified by the *SCDHHS Contract*. CCME identified deficiencies from the previous EQR has been addressed.

As noted in *Figure 9: State Mandated Services*, Select Health receives a 2018 score of "Met" for 100% of the standards in the State Mandated Services section.

Figure 9: State Mandated Services

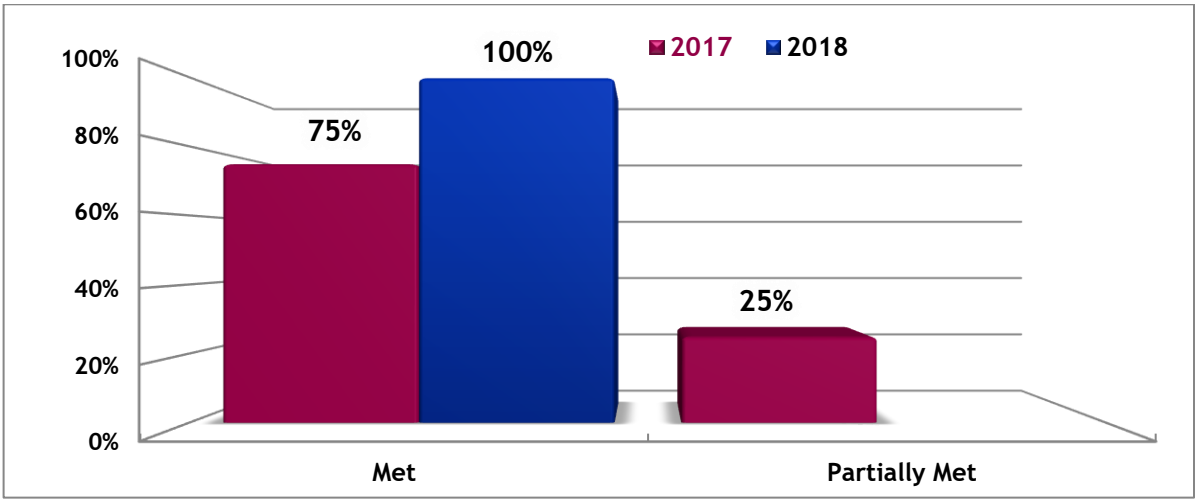


TABLE 14: State Mandated Services Comparative Data

SECTION	STANDARD	2017 REVIEW	2018 REVIEW
State Mandated Services	The MCO addresses deficiencies identified in previous independent external quality reviews.	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Strengths

- The member and provider portals show missed and upcoming recommended services.

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 24, 2018

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 2018 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 8th and 9th**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **October 8, 2018.**

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

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 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 2018

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. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

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

10. The Quality Improvement work plans for 2017 and 2018.

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 2018 through September 2018. 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 2017 through September 2018.

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

36. Provide electronic copies of the following files:
    a. Credentialing files (including signed Ownership Disclosure Forms) 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 (including signed Ownership Disclosure Forms) 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 2017 through September 2018. 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 2017 through September 2018, 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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2018

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Quality of Clinical Care Committee minutes for: October 2017 – October 2018. We received the minutes for the meetings in May 2018 and July 2018.
3. Several credentialing and/or recredentialing files were missing information or need explanation. See attached list.

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:	2017
Review Performed:	11/2018

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 by in-house 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 uses 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:	11/2018

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 are 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 is defined clearly.
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 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 utilized.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	HEDIS Hybrid methodology utilized.

Component / Standard (Total Points)	Score	Comments
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 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 is provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The personnel who are involved in the data collection and their qualifications are mentioned on page 19.
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 are 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 is conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented clearly for the rates.
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 and one remeasurement 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 includes 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 used for measures that are still included in the project.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Improvements in rates for HbA1C >9 as shown by a decrease in rates. HbA1C <8 rate is increasing and improving; Controlling BP increase (improved).
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)**	**MET**	Improvement appears to be a result of the interventions implemented.

Component / Standard (Total Points)	Score	Comments
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NOT MET**	Statistical significance is demonstrated using z-tests, but the p-values are not properly documented. *Recommendation:* *The actual p-value that is a result of the comparison needs documentation. It is p=.652 for the first measure, p=.230 for HbA1C<8, and p=.009 for controlling BP <140/90 when conducted. Instead of <.00001, present the calculated p-value.*
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Data are reported for baseline and one remeasurement only, thus, too early to judge.

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
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	0
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	110
Project Possible Score	111
Validation Findings	99%

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:	11/2018

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 is selected based on data analysis for CY2015 and later.
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 defined clearly.
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.
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 is defined clearly.
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.

Component / Standard (Total Points)	Score	Comments
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 used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection conducted according to HEDIS specifications
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan provided as per HEDIS specifications.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The personnel who are involved in the data collection and their qualifications are documented.
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 addressed by interventions are 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 conducted according to plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results presented clearly for the rates.
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)**	**MET**	Baseline and one remeasurement are presented for both outcomes.

Component / Standard (Total Points)	Score	Comments
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 includes 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 used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rates for both 7 day and 30 day follow up show improvement.
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)**	**MET**	Improvement appears to be based on resolving the data mapping issues discovered.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical significance is demonstrated using z-tests and p-values are computed to be 0.00, so they are documented properly as <.00001.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Sustained improvement cannot yet be determined.

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
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	NA	NA
5.2	NA	NA
5.3	NA	NA
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	91
Project Possible Score	91
Validation Findings	100%

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 Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2018
Review Performed	11/2018

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: *Adult Medicaid Summary Report- Select Health Final RY18*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation *Adult Medicaid Summary Report- Select Health Final RY18*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation *Adult Medicaid Summary Report- Select Health Final RY18*

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: *Adult Medicaid Summary Report- Select Health Final RY18*
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 *Adult Medicaid Summary Report- Select Health Final RY18*

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 defined. clearly Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame are defined clearly. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy is appropriate. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
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 has a sample size of 1,674 eligible members. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures used to select the sample. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*

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 are aligned with NCQA protocol and are clear and appropriate. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
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=345 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 and the NCQA 2017 national average of 23%. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18* *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 is in place. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*

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: *Adult Medicaid Summary Report- Select Health Final RY18*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18*

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 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%, thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Select Health of South Carolina members gave the highest ratings of satisfaction to the composite measures for Getting Needed Care and Customer Service (95th percentile). Shared Decision Making received the lowest rating (25th percentile). Documentation: *CAHPS Adult 2018 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: *Adult Medicaid Summary Report- Select Health Final RY18; CAHPS Adult 2018 Analysis*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *Adult Medicaid Summary Report- Select Health Final RY18; CAHPS Adult 2018 Analysis*

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2018
Review Performed	11/2018

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: *Child CCC Medicaid Summary Report-Select Health Final RY18*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*

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: *Child CCC Medicaid Summary Report-Select Health Final RY18*
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: *Child CCC Medicaid Summary Report-Select Health Final RY18*

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 is defined clearly. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame are defined clearly. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
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 3,479 eligible members. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures used to select the sample. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*

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: *Child CCC Medicaid Summary Report-Select Health Final RY18*

Survey Element		Element Met / Not Met	Comments And Documentation
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 for the total sample was 26% (n=891 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, but above the 2017 NCQA national average of 22%. The response rate for the general population was 24% and did not meet the target number of valid surveys (n=395). Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents and work toward NCQA target rate.*

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 is in place. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures followed. Documentation: *Child CCC Medicaid Summary Report-Select Health Final RY18*

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 analyzed. Documentation: *Child CCC Medicaid Summary Report- Select Health Final RY18*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *Child CCC Medicaid Summary Report- Select Health Final RY18*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions supported by findings. Documentation: *Child CCC Medicaid Summary Report- Select Health Final RY18*

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 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 26% for the total sample and 24% for the general population. These are below the target response rate according to NCQA of 40.0%. Thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	Select Health did not analyze Child with CCC information in the CAHPS 2018 Analysis document. *Recommendation: In addition to analysis of the Child and Adult reports, review and analyze the Child CCC report from Morpace to determine opportunities for improvement regarding key drivers and composite scores.*
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 not conducted. *Recommendation: In addition to analysis of the Child and Adult reports, review and analyze the Child CCC report from Morpace to determine opportunities for improvement regarding access and quality of care.*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information provided and documented. Documentation*: Child CCC Medicaid Summary Report- Select Health Final RY18*

CCME EQR Survey Validation Worksheet

Plan Name	**Select Health**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2018
Review Performed	11/2018

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: *Child Medicaid Summary Report- Select Health Final RY18*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives are documented clearly. Documentation *Child Medicaid Summary Report- Select Health Final RY18*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience is identified and documented. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*

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: *Child Medicaid Summary Report- Select Health Final RY18*
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: *Child Medicaid Summary Report- Select Health Final RY18*

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 is defined clearly. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
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 2,057 eligible members. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures used to select the sample. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*

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: *Child Medicaid Summary Report- Select Health Final RY18*
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=492 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, but above the 2017 NCQA national average of 22%. Documentation: *Child Medicaid Summary Report- Select Health Final RY18* *Recommendation: Implement strategies to increase response rates and work with vendor to find ways to reach more respondents and work toward NCQA target rate.*

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 is in place. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation follows the planned approach. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures followed. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*

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 analyzed. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests conducted. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions supported by findings. Documentation: *Child Medicaid Summary Report- Select Health Final RY18*

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% which is above the national average for 2017 which was 22% but below the target response rate according to NCQA is 40.0%. Thus, caution should be utilized when generalizing the results to the population.
7.4	What conclusions are drawn from the survey data?	The Child Medicaid results show Select Health responses in the 97th percentile for Rating of Health Plan and 92nd percentile for Rating of Health Care. The lowest ratings were for Getting Needed Care. Documentation: *CAHPS 2018 Analysis Child Adult*
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 conducted. Documentation: *CAHPS 2018 Analysis Child Adult*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information provided and documented. Documentation*: Child Medicaid Summary Report- Select Health Final RY18, CAHPS 2018 Analysis Child Adult*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Select Health of SC**
Collection Date:	2018

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					Requirements for development, review, revision, and approval of policies are included in Policy 168.108, Development and Implementation of Policies & Procedures, and Policy SHC 168.001, Policy & Procedure Program Management & Format Guidelines. Policies are reviewed at least annually and revised as needed. Staff can access policies via a shared drive and iNSIGHT, a local intranet site. Department heads are responsible for ensuring all applicable staff review new and revised policies.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (CEO, COO, Executive Director);	X					Courtnay Thompson is the Market President, responsible for general oversight, administration, and implementation of the health plan. The Director, Plan Operations and Administration position is vacant as noted on the organizational chart. Onsite discussion confirmed the health plan is actively working to fill this position.
1.2 Chief Financial Officer (CFO);	X					Sean Popson is the Director, Finance and fulfills the functions of a Chief Financial Officer. He reports to the Vice President, Corporate Finance, Sharon Duncan.
1.3 * Contract Account Manager;	X					James King is the Contract Account Manager.
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Claims Processing and Encounters Management Operations are conducted in Philadelphia, PA by AmeriHealth Caritas staff.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					Claims Processing and Encounters Management Operations staff include an Encounter Management Analyst, a Claims Supervisor, Team Leads, Claims Examiners, and Analysts.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Utilization Management (Coordinator, Manager, Director);	X					Kathy McElheney is the Regional UM Director. Janis Power is Regional Integrated Health Care Management (IHCM) Director, and Andrea Kilburn-Conyers is Director of Integrated Care Management. All are Registered Nurses licensed in South Carolina. Cheryl Stockford is Director of Behavioral Health Integration (UM/CM) and is a South Carolina Licensed Independent Social Worker.
1.5.1 Pharmacy Director,	X					The Regional Pharmacy Director is Jay Messeroff, a SC-licensed Pharmacist, and the Pharmacy Manager is Shalis Lightner, Certified Pharmacy Technician. The Pharmacy Supervisor is Melissa Abad, Certified Pharmacy Technician.
1.5.2 Utilization Review Staff,	X					The UM Review Manager is Linda Waters, and Nancy Smith is a Supervisor of UM Review. Two vacancies were noted on the organizational chart for Supervisors of UM Review. Onsite discussion revealed one of the vacancies was filled and the health plan is actively seeking to fill the second.
1.5.3 *Case Management Staff,	X					Case Management (CM) staff includes Supervisors, Case Managers (medical and behavioral health), Care Connectors, and a Child Welfare Liaison, and are located in South Carolina.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Nathanial Patterson is the Director of Quality Management, and Alesia Boling is the Manager of Quality Management. Both report to Brenda

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Myrick, Vice President, Quality Programs and Accreditation.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Quality Assessment and Performance Improvement staff include a Team Lead, Quality Performance Specialists, Community Health Navigators, and an Accreditation Specialist. According to the organizational chart, a Data Analyst position is vacant. Onsite discussion revealed the position is in the process of being filled, and the corporate data analytics team is supporting the local team in the interim.
1.7 *Provider Services Manager;	X					Peggy Vickery serves as Director of Provider Network Management, and Philip Fairchild is the Director of Provider Network Operations.
1.7.1 *Provider Services Staff,	X					Provider Services staff include, but are not limited to, Provider Network Analysts, Provider Network Account Executives, and Provider Network Coordinators.
1.8 *Member Services Manager;	X					The Director of Member Services position was vacated recently and Toni Parnell (Manager of Member Services) is serving as the Director until the position is filled. Margaret Johnson is Supervisor of Member Services. Josue Valentin and Erin Gleaton are Contact Center Supervisors.
1.8.1 Member Services Staff,	X					Select Health's organizational chart reflects a total of 53 Customer Service Representatives (CSRs). The organizational chart indicates three of the CSRs report to Margaret Johnson; however, it does not clearly indicate to whom

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the remaining 50 CSRs report. Onsite discussion confirmed they report to Josue Valentin. *Recommendation: Revise the organizational chart to clearly indicate to whom all CSRs report.*
1.9 *Medical Director;	X					The Market CMO is Kirt Caton, MD. Additional Medical Directors include: •Cathryn Caton, MD •Courtney Jones, MD •Leigh Spicer, MD •Roger Beardmore, PsyD •Melissa Pearce, MD The *Quality Assessment and Performance Improvement Program Description* defines roles and responsibilities of the Regional CMO on page 19 but contains no information about the Market CMO. Onsite discussion confirmed this page of the program description should be revised to refer to the Market CMO. *Recommendation: Revise page 19 of the Quality Assessment and Performance Improvement Program Description to refer to the Market CMO rather than the Regional CMO.*
1.10 *Compliance Officer;	X					Deonys de Cardenas is Director of Compliance and serves as Select Health's Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					Elizabeth Saragusa is the Program Integrity Coordinator.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					During discussion with Select Health staff, it was revealed that Diane Rowan is the Interagency Liaison; however, this contractually-required position is not indicated on the organizational chart. *Recommendation: Ensure that all contractually-required positions are reflected in the organizational chart.*
1.12 Legal Staff;	X					Legal Affairs is housed in Philadelphia, PA, under the direction of Senior Vice President of Legal Affairs, Eileen Coggins, and Senior Counsel, Robert Tootle.
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Roger Beardmore fills this role.
1.14 Post-payment Review Staff.	X					The Payment Integrity team conducts post-payment review functions and has four staff who work exclusively on South Carolina operations, with an additional three staff who dedicate 50% of their time to South Carolina operations. Five staff members are physically located in South Carolina. The *Program Integrity Plan*, page 2, indicates staff includes "experienced investigators and analysts, with certified professional coders, registered nurses, certified fraud examiners, and accredited health care fraud investigators." This is consistent with documentation noted on the Special Investigations Unit (SIU) Organizational Chart.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Select Health's ISCA documentation indicates internal standards for timeliness of claims processing are 90% of clean claims paid in 30 days of receipt, and 99% of all claims paid within 90 days of receipt. Additionally, the documentation notes that Select Health supervisors review claim inventory reports daily to ensure claims processing requirements are met.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Select Health's ISCA documentation states its infrastructure can receive electronic files and an Electronic Data Interchange (EDI) process verifies that electronic claim data conforms to HIPAA SNIP Level 5 compliance standards.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Membership files are processed daily, and any modifications of demographic information, category of assistance, change of medical assistance, eligibility, new enrollment, disenrollment, or PCP change is updated automatically. Additionally, Select Health has scheduled processes to check demographics and verify the accuracy of enrollment data.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Select Health uses systems that run National Committee for Quality Assurance (NCQA) Certified HEDIS software for calculating continuous enrollment. Analysts review the work of the performance measurement reporting team and the Manager of HEDIS Reporting approves performance measurements.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Data privacy assessments of Select Health's infrastructure are conducted, and the results measured against HIPAA regulations and industry standards. The audit report indicates that the MCO's infrastructure, security controls, and procedures are capable of maintaining the confidentiality, integrity and availability of electronic protected health information (PHI).
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					The ISCA documentation includes a listing and summary of the current data security policies used by the MCO. Additionally, the plan provided details for document and data retention policies and procedures.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Select Health provided a very detailed disaster recovery plan that addresses all the areas needed to respond disasters of varying magnitudes. The DR plan includes assessment guides to determine disaster severity and checklists to perform a post-mortem review. During the most recent DR plan testing, all recovery objectives were achieved.
I D. Compliance/Program Integrity						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The *2018 Select Health of South Carolina Compliance Program and Program Integrity Plan* and associated policies define requirements and guide staff executing Compliance and Program Integrity functions.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The *2018 Select Health of South Carolina Compliance Program* confirms a Code of Conduct and Ethics (Code) is maintained to provide comprehensive information and guidance on standards of ethical behavior and compliance with federal and state laws. The Code defines expectations for actions and behaviors and applies to all staff, including the Board of Directors (BOD), officers, contingent staff, subcontractors, and vendors. As applicable to Select Health, the Code of Conduct and Ethics is made available at the time of appointment or hire and annually thereafter. Employees participate in a formal, annual training process. Policy 115.600, Progressive Discipline Policy indicates Select Health and AmeriHealth Caritas enforce compliance and ethical standards through well-publicized disciplinary guidelines that reflect clear, specific disciplinary policies and consequences for violating the Code of Conduct and Ethics. The policies are made available upon hire and annually by various means including training and the corporate intranet.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Officer oversees and manages the Compliance Program and reports directly to the Market President. The Compliance Officer also reports directly to the BOD. The Program Integrity Coordinator coordinates Fraud, Waste, and Abuse (FWA) activities with SCDHHS' Program Integrity/Surveillance Utilization Review Division.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The *2018 Select Health of South Carolina Compliance Program* contains information about the Compliance Committee's purpose, activities, meeting frequency, and membership.
2.5 Compliance training and education;						As noted above, Select Health conducts annual Compliance training that includes the False Claim Acts; Anti-Kickback Statute; Deficit Reduction Act; Fraud Enforcement and Recovery Act (FERA); Health Insurance Portability and Accountability Act (HIPAA); and Health Information Technology for Economic and Clinical Health Act (HITECH). The training also includes topics such as Embracing a Culture of Compliance; Compliance Laws (including State-specific training on FWA laws and whistleblower protections); Fraud, Waste, and Abuse; HIPAA/Privacy, Security Awareness, Code of Conduct and Ethics, and Conflict of Interest policy requirements. Annual Compliance trainings are mandatory and must be completed within 30 days of issuance.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						As stated in Policy NM 159.102, Provider Orientation and Ongoing Training, training is offered to all providers and provider staff about requirements of the state contract and providing services to Medicaid members. Initial training is provided within 30 calendar days of a newly contracted provider/group being placed on active status, and ongoing training is conducted as necessary to ensure compliance with program standards. Select Health has developed a comprehensive *Provider Training Presentation* that includes information about FWA, the phone number and mailing address for the Select Health Fraud and Abuse Hotline, and the phone number and email address for South Carolina's Division of Program Integrity Fraud and Abuse Hotline.
2.6 Lines of communication;						Select Health maintains anonymous hotlines for reporting compliance issues and suspected FWA. Reports may be also submitted online and via email. Reporting methods are posted throughout Select Health facilities and are distributed to staff periodically. Select Health enforces a strict non-retaliation policy for good-faith reporting of concerns.
2.7 Enforcement and accessibility;						Select Health enforces compliance and ethics standards through well-publicized disciplinary guidelines that reflect clear, specific disciplinary policies and the consequences of violating the Code of Conduct and Ethics. The policies are made available upon hire and annually by various means, such as formalized training, and are available on the intranet.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy 115.600, Progressive Discipline Policy applies to all associates in all AmeriHealth Caritas lines of business. It defines the levels of discipline for violations of policy, standards of conduct, etc.
2.8 Internal monitoring and auditing;						The *2018 Select Health of South Carolina Compliance Program* indicates "routine monitoring and auditing are critical elements to an effective compliance oversight program. Routine monitoring and auditing activities include both initial testing for compliance metrics and validation reviews to confirm ongoing compliance and appropriate resolution of remediation and corrective actions." Components of routine monitoring and auditing are addressed and defined in the *2018 Select Health of South Carolina Compliance Program*.
2.9 Response to offenses and corrective action;						The *2018 Select Health of South Carolina Compliance Program* defines protocols for responding to noncompliance and offenses, including internal or external warning letters; internal remediation and corrective action initiatives; investigation protocols for FWA; and affirmative reporting to regulatory agencies as appropriate.
2.10 Data mining, analysis, and reporting;						Policy 106.600.003, Internal Prospective Data Mining defines procedures for data mining and states the Program Integrity Department is charged with preventing, detecting, investigating, and reporting FWA. The department has cross-functional teams to support its program and ensure the accuracy,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						completeness, and truthfulness of claims and payment data and all relevant state and federal laws and regulations. As part of the program, the Program Integrity Data Analytics Team (Data Mining Team) prospectively mines data to identify and avoid provider overpayments.
2.11 Exclusion status monitoring.						The *2018 Select Health of South Carolina Compliance Program* addresses initial and ongoing monitoring of providers, owners, agents, and managing employees. All associates, contingent workforce members, subcontractors, vendors, and contracted providers are monitored, upon hire or engagement, and monthly thereafter, to ensure they are not excluded from participation.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Committee meets quarterly and monitors the Compliance Program. Activities include receiving reviews and findings from the Compliance Officer; making recommendations for the *Annual Compliance and Privacy Work Plan*; and providing guidance for all compliance initiatives and activities. Committee membership is documented in the *2018 Select Health of South Carolina Compliance Program*, the *Compliance Committee Charter*, and *Compliance Committee Listing* consistently.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The *2018 Select Health of South Carolina Compliance Program* defines protocols for responding to noncompliance and offenses, including internal or external warning letters; internal remediation and corrective action initiatives; investigation protocols for FWA; and affirmative reporting to regulatory agencies as necessary or appropriate. Additional information is found in Policy 168.104, Compliance Investigation, Inquiries and Non-retaliation Policy.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy 106.200.003, Vendor Retrospective Overpayments and Recoveries – Data Mining indicates Select Health uses a Program Integrity vendor to assist in the retrospective identification and recovery of provider overpayments. The Program Integrity Reporting and Recovery Team is responsible for the overall management of internally and externally identified recovery projects. Additional documentation is noted in the Program Integrity Plan and Policy 106.100.010, Prepayment Review.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy MED (PA) 150.402, Beneficiary Lock-In Program addresses requirements and processes for the Pharmacy Lock-in Program.
I E. Confidentiality						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 defines requirements and procedures for protection of protected health information (PHI) as well as other confidential or proprietary information. Additional information is supplied in a multitude of additional Corporate Compliance policies. All associates and contractors receive training on the maintenance of the privacy and security of PHI upon hire and annually thereafter. Additional training is provided as policies and procedures change and applicable to job roles and responsibilities. Select Health mails the *Notice of Privacy Practices* (NPP) with enrollment materials to new members. Members are notified of the availability of the NPP at least every 3 years. The NPP is available electronically to users who log on to Select Health's website, and links to the NPP are prominently displayed on websites. Paper copies are provided upon request. When the plan makes material revisions to the NPP, all members are mailed a copy of the revised NPP within 60 days of the effective date of the revision. Employees, contractors, external committee members, etc. sign a confidentiality agreement annually.

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					The *Credentialing Program 2018*, Policy CR.100.SC, Health Care Professional Credentialing and Recredentialing, and several additional policies address provider credentialing and recredentialing.
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. Kirt Caton, Market CMO, chairs the Credentialing Committee. Additional voting members include a Behavioral Health Medical Director, Regional UM Medical Director, a network Certified Registered Nurse Practitioner, and four network physicians with specialties in pediatrics, family practice, and orthopedic surgery. Select Health also utilizes three additional members (two Medical Directors and an OB/GYN network physician) ad hoc, and they vote only when attending a meeting. The committee meets monthly, or a minimum of 11 times a year. A quorum is established upon attendance of at least 50% of voting members, and the committee chair votes only in the event of a tie. A review of committee meeting minutes reflects quorums met and active committee member participation.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Credentialing files are organized and contain appropriate documentation.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
3.1.10 Query of the State Excluded Provider's Report, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List;	X					Per Onsite discussion, the *CMS Adverse Action Report List* is no longer a query required by SCDHHS.
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					Select Health utilizes a vendor called ProviderTrust for queries of the Social Security Death Master file. Proof of queries are in the credentialing/ recredentialing files.
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					
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 are organized and for the most part contain 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					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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, the SC Providers Terminated for Cause list, and the CMS Adverse Action Report List;	X					Per Onsite discussion, the *CMS Adverse Action Report List* is no longer a query required by SCDHHS.
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
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				The majority of the recredentialing files reviewed contained outdated *Ownership Disclosure Forms*. Files reflect forms signed in years 2010, 2013,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						2015, 2016, and 2017. The form signed in 2010 was form 1513 instead of the required *Form 1514*. Onsite discussion confirmed that while Select Health has a separate process to collect and update *Ownership Disclosure Forms*, the recredentialing process never included pursuing or reviewing updated forms. *Quality Improvement Plan: Ensure the recredentialing process includes collecting updated Ownership Disclosure Forms.*
4.3 Review of practitioner profiling activities.		X				Policy CR.107.SC, Actions Reporting Health Care Professional 2018 states that Select Health reviews the participation of health care professionals/ providers whose conduct could adversely affect the health and welfare of members. Potential quality of care (QOC) concerns are investigated and the Medical Director's outcome determination of the QOC concern may render a referral to the Credentialing Committee for further review. The Committee may recommend action including, but not limited to, panel restriction or termination from the plan. Policy CR.104.SC, Ongoing Monitoring – Licensure and Medicare/Medicaid Sanctions states the Credentialing Department receives a *Quality of Care Concerns report* from the Quality Department quarterly. Providers who meet the threshold of greater than three (3) grievances for service quality issues may be submitted to the Credentialing Committee for review to determine if intervention is warranted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy CR.100 SC, Health Care Professional Credentialing and Recredentialing does not address how Select Health considers provider performance during recredentialing. *Quality Improvement Plan: Update Policy CR.100 SC, Health Care Professional Credentialing and Recredentialing to include Select Health's process of considering a provider's performance in the recredentialing process.*
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					Select Health investigates, monitors, reports, and notes trends of potential quality of care concerns that are identified from internal and external sources. Quality of care concerns are processed and action is taken according to the severity and potential for future harm associated with the incident. Procedures are addressed in Policy QI 154.010, Review of Potential Quality of Care Concerns. Policy CR.107.SC, Actions & Reporting Against Health Care Professional/Provider for Quality details the process for conducting sanctioning activities and compliance with reporting requirements. A health care professional/provider may appeal proposed formal sanctioning decisions to a Plan Hearing Panel as defined in Policy CR.112.SC, Credentialing/Re-credentialing Provider Denial, Termination or Reconsideration Appeal Process.
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 defines the credentialing/recredentialing process for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						organizational providers. File review of organizational providers showed appropriate documentation.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					The process of monitoring licensure sanctions, Medicare/Medicaid sanctions, data bank activity, and potential quality of service issues monthly is defined in Policy CR.104.SC, Ongoing Monitoring-Licensure and Medicare/Medicaid Sanctions.
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					Policy NM 159.206, Availability of Practitioners defines guidelines regarding compliance with geographic access standards for PCP, OB/GYN, and required physician specialists. The geographic standards are monitored annually through GEOAccess reports and results are reported to the Quality of Service Committee (QSC) and the Quality Assessment Performance Improvement Committee (QAPIC). Several reports in the desk materials report results of network evaluation in 2018 for PCPs, behavioral health providers, and specialists. Results for PCPs and pediatricians show member to provider ratios meet the defined standards, and geographic

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						availability meets 100% compliance for urban/ suburban and rural standards.
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 defines the geographic standards for specialists as one within 30 miles for urban and one within 50 miles for rural. Hospitals are measured as one within 50 miles. High volume specialists are measured with a provider to member ratio of 1:5000. The geographic standards for behavioral health are defined in Policy NM 159.304, Behavioral Health Availability. Annually, or "as needed" Select Health measures availability and member ratios for behavioral health required providers to include Psychologists, Psychiatrists, Licensed Professional Counselors (which include Licensed Independent Social Workers Licensed Marriage and Family Counselors and Licensed Psycho-Educational Therapists), and Rehabilitative Behavioral Health providers. The *2018 PCP and Specialist Availability Report* shows various specialties where the geographic availability standards are 100% compliant; nephrology is 99.6% for urban/suburban. All specialties meet the provider to member ratios except allergy/immunology. Interventions include recruiting allergy/immunology providers and recruiting a nephrologist in York County. The *2018 Behavioral Health Availability Report* geographic and provider to member ratios meet 100% compliance to the defined standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					
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 states that Select Health is committed to maintaining a provider network that meets the cultural, linguistic, and special needs of its health plan population. The organization requests race, ethnicity and language (REL) data and information related to accommodating people with mental and/or physical disabilities from contracted network providers and office support staff on a voluntary basis through provider visits as well as the organization's credentialing and re-credentialing process. Cultural competency training is offered to providers on the website.
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 *Provider Directory* is available on the website with user-friendly searchable options that comply with contract guidelines. Members can contact Member Services for a paper copy of the *Provider Directory*. Policy NM 159.308, Assessment of Physician Directory Accuracy states that Select Health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						evaluates the accuracy of physician data elements that are reflected in plan physician directories by multiple processes (internal and external) that are conducted weekly, monthly and/or annually. Routine data updates are made to the online physician directory daily based on change forms submitted by Account Executives or directly from providers and are sent to corporate provider data maintenance to update provider information.
3.Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Policy NM 159.203, Accessibility of Services defines the annual process by which PCPs and high-volume/high-impact specialty physicians are evaluated for compliance with plan established accessibility standards. The objective is to have 90% of the provider offices meet or exceed access standards set by Select Health. Annually, the Account Executives conduct an after-hours survey for a statistically valid sample of PCP locations to be sure that they meet the 24- hour accessibility standard. Corrective Action Plans (CAP) are initiated for non-compliant providers. The policy defines appointment standards that comply with contract guidelines. Additional availability analysis includes reviewing member grievances and analyzing the results of the plan's annual *CAHPS Survey*. However, the policy does not address the plan's process for conducting telephone access studies about provider adherence to appointment standards.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Results of the PCP afterhours survey and the PCP and Specialty (high-volume/high-impact) Accessibility Surveys conducted in 2017 were provided in the desk materials. Overall appointment accessibility among PCPs met the Select Health designated access rate of 95% for existing patients for Emergent, Urgent, and Routine care. New Patient access to Primary Care is trending lower than desired. The High volume and High Impact Specialties were not met for many of the specialists evaluated, in particular for new patients. 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. However, the policy does not address the plan's process for conducting telephone access studies about behavioral health provider adherence to appointment standards. The *2017 Behavioral Health Accessibility Survey* administered telephonically showed Prescriber and Non-Prescriber accessibility results fell below the 95% compliance goal for all behavioral health access standards. Rates of compliance were particularly low among prescribing physicians, most likely due to the shortage of psychiatrists nationwide. However, the Select Health behavioral health access to appointments improved for Urgent and Emergent levels of care for existing patients from 2016.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update Policy NM 159.203, Accessibility of Services, and Policy NM 159.306, Accessibility of Behavioral Healthcare Services to include Select Health's process for conducting telephone access studies to assess provider adherence to appointment standards.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.			X			During the *Telephonic Provider Access Study*, calls were successfully answered 50% of the time (113 out of 224) when omitting calls answered by personal or general voicemail messaging services. When compared to 2017 results of 55%, the 2018 study has a non-statistically significant decrease in successful calls (p=.242). For calls not answered successfully (n=111 calls), 71 (64%) were unsuccessful because the provider was not at the office or phone number listed. Of the 113 successful calls, 102 (90%) of the providers indicated that they accept Select Health, although one (<1%) indicated that this occurred only under certain conditions. Of the 101 who accept Select Health, 77 (76%) responded they are accepting new Medicaid patients. Regarding a screening process for new patients, 33 (44%) of the 75 providers who responded indicated that an application or prescreen was necessary for new patients. Of those 33, 5 (15%) indicated that an application must be completed whereas 11 (33%) require a review of medical records before accepting a new patient, and 9 (27%) required both. When asked about the next available routine

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appointment, 52 (76%) of 68 responses met contract requirements. It was noted during the Onsite that Select Health has a Provider Network Management workgroup tasked with ongoing assessment of provider access. In addition, routine data updates are made by Account Executives who visit provider offices and when change requests are received directly from a provider. *Quality Improvement Plan: Update provider contact information more frequently to maintain accurate contact information.*
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Policy NM 159.102, Provider Orientation and Ongoing Training states the Provider Network Management department is responsible for conducting provider orientation and ongoing training. Provider orientation is conducted within 30 calendar days for newly contracted providers or provider groups. In office training sessions are documented via the *Provider Encounter Form* and trends are monitored. Select Health provided a comprehensive provider training presentation and a behavioral health provider training presentation in desk materials along with copies of provider communications. The *Provider Manual* is updated annually and is a useful reference document for providers.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 NM 159.102, Provider Orientation and Ongoing Training states the Account Executive conducts orientation sessions, makes educational visits, functions as a pro-active practice account leader, and coordinates resolution of provider issues. The Provider Network Operations Communications Specialist conducts annual regional provider trainings as defined in Policy PNO 170.205, Ongoing Provider Training. Additional educational opportunities include site visits via Provider Network Management, mailings and newsletters to providers, webinars, the *Provider Manual*, and information on the website.
II D. Primary and Secondary Preventive Health Guidelines						
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					Guidelines are developed utilizing criteria established by nationally recognized professional organizations and with input from network PCPs and specialists. Clinical practice and preventive guidelines are developed based on demographic composition of the population. Guidelines are reviewed at least every two years and when more current information becomes available. Once the practice guidelines are approved and adopted by

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Clinical Policy Committee, they are reviewed and approved by the QAPIC.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Guidelines are distributed to practitioners via the *Provider Manual*, the website, and 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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Corporate Policy 154.200, Preventive Health and Clinical Practice Guidelines defines the procedures for adopting and reviewing practice guidelines. Guidelines are based on recommendations from professional organizations, peer-reviewed literature, and input on local practice patterns from participating Select Health practitioners. Guidelines are reviewed at least every two years and when more current information becomes available. Several documents in the desk materials support the adoption of clinical practice guidelines; however, there were inconsistencies as follows: •Memo from Dr. Kirt Caton to the QIC on September 27th, 2018 lists titles of clinical practice guidelines and several relating to Asthma were not found on the website such as Asthma Children 0-4 years, Asthma Children 5-11, Asthma General Principles, and Asthma Youth 12 Years and Older and Adults. •The *Clinical Practice Guidelines* listed on pages 35-36 of the *2018 QAPI Program Description* do not match the *Clinical Practice Guidelines* listed in the *Corporate Clinical Guidelines* document provided in the desk materials; some guidelines are different and some web-links are outdated or do not work.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure adopted clinical practice guidelines are consistent between documents and the website and all web-links are usable.
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					Guidelines are distributed to practitioners via the *Provider Manual*, the web, and direct mailings.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy QI 154.011, Monitoring Continuity and Coordination of Care defines the mechanisms for monitoring the delivery of care to plan members in detecting continuity and coordination of care potential problems. As discussed during the Onsite visit, coordination of care is monitored when the member is in CM, but CCME found no evidence that monitoring occurs for members who are not in CM. *Recommendation: Follow the process outlined in Policy QI 154.011, Monitoring Continuity and Coordination of Care for monitoring continuity and coordination of care.*
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy QI 154.009 defines the procedures for monitoring the quality of practitioner medical records. The Medical Record Review (MRR) is conducted at least annually in conjunction with the plan's annual HEDIS survey. The MRR is completed either through onsite medical record review or by reviewing requested medical records received. Select has adopted medical record-keeping standards to ensure complete and consistent documentation of patient medical records which are vital to quality patient care.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					The *Provider Manual* contains detailed information regarding adopted medical record documentation standards that comply with contract requirements.
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The *2018 Medical Record Documentation Review* states the annual assessment was completed in May 2018. A random sample of 20 primary care practices was chosen from this sample for additional assessment against the medical record review standards. The benchmark/goal is to ensure that 90% of the medical records reviewed from each provider office surveyed are in compliance with the plan's policy for medical record documentation standards. The overall 2018 Medical Record Review compliance rate is 97.887%, exceeding the plan's goal of 90%. This represents a 3.68% increase from the rate of 94.4% in 2017. Although the plan met its overall goal of 90% in 2018, Select Health recognizes that opportunities remain for improvement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy MEM 129.100, Member Rights and Responsibilities defines both the rights to which members are entitled and member responsibilities. A new member packet sent to members at enrollment describes how members can view their rights and responsibilities online or receive a paper copy. Instructions for obtaining a copy of rights and responsibilities are published annually in member newsletters and posted on the website. Customer Services Representative also attempt to contact

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						each member household to discuss rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					Member rights are consistently documented across Policy MEM 129.100, Member Rights and Responsibilities, the *Member Handbook*, the *Provider Manual*, and on the First Choice website.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
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);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:		X				New member packets are mailed within 30 calendar days from receipt of enrollment data from SCDHHS. CSRs conduct orientation calls with new member households within two weeks of enrollment, providing members with a scripted orientation of the plan. PCP selection is encouraged during this orientation call and members are assisted with selecting a PCP if needed. Select Health maintains a *Member Handbook List of Changes* on the website. See standards below for identified issues.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						Select Health supplies members with a *Co-Payment Reference Guide* along with the *Member Handbook* at the time of enrollment.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Page 24 of the *Member Handbook*, item 16, states it is a member right to receive detailed information about emergency and after-hours coverage, to include but not limited to, "what constitutes an emergency medical condition, emergency services and post-stabilization services." No other information or explanation is in the *Member Han*dbook about post-stabilization care. During Onsite discussion, Select Health staff did not define alternate methods of educating members about post-stabilization care or services. *Quality Improvement Plan: Revise the Member Handbook to include member-appropriate information explaining post-stabilization care and coverage.*
1.7 Policies and procedures for accessing specialty care;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						The list of member rights in the *Member Handbook* includes that members have the right to receive notice of significant changes in the benefits package (services, benefits, and providers) at least 30 days before the intended effective date of the change. The *Member Handbook* does not specify how the plan provides this notification. *Recommendation: Update the Member Handbook to include information about how members are notified of a significant change in services, benefits, and providers.*
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						The *Member Handbook*, page 30, states, "Your baby will be covered by First Choice from the date of birth. Your baby will stay on First Choice for the rest of his or her first year unless you change to another managed care plan during the second or third month of your baby's life. In this case, your baby will be moved to the new plan with you unless you want your baby to stay on First Choice." As written, this sounds as if the baby can only change plans if the mother (member) changes plans. The *SCDHHS Contract, Section 3.14.5*, states newborns are automatically enrolled for the birth month and that the member may choose to enroll the newborn

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						in another health plan after delivery by contacting Healthy Connections Choices. There is no requirement in the contract that the member must also change plans. *Quality Improvement Plan: Correct page 30 of the Member Handbook to remove the requirement that the member must change plans in order to enroll the newborn in a different plan.*
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						A description of the *Provider Directory* is found in the *Member Handbook* along with instruction to access the *Provider Directory* on the website. Members are instructed to contact Member Services to find out more about a provider or to request a *Provider Directory*.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						A definition of well-child/Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits is included on page 16 of the *Member Handbook*. More detailed information about EPSDT services, including the recommended schedule of visits for EPSDT services, is found on pages 20-21 of the handbook. Appropriate information about EPSDT services is found on the Member's section of the website. The following issues were noted in EPSDT information found in the Provider's Section of the website: •A reference to Pennsylvania's *EPSDT Periodicity Schedule and Coding Matrix*. The *SCDHHS Contract, Section 4.2.10.2* requires using the *Bright Futures/American Academy of Pediatrics Medical Periodicity Schedule*. •Missing links in three locations on the same webpage. *Quality Improvement Plan: Revise the provider's section of the website to correct the missing links and to refer providers to the Bright Futures/AAP Medical Periodicity Schedule.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						The *Member Handbook* contains a comprehensive, member-appropriate explanation of Advance Directives. Members are instructed to contact the South Carolina Lieutenant Governor's Office on Aging (at the provided phone numbers) or Member Services for more information.
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Members are notified annually of their right to request a *Member Handbook* or *Provider Directory*. This most recently occurred in the Summer 2018 issue of the *Healthy Now* newsletter.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Requirements and processes for notifying members of changes in benefits and changes to the provider network are defined in policies MEM 129.117, Termination of Primary Care Provider, MEM 129.125, Termination of a Specialist or Hospital, and MEM 129.105, Member Services Department.
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy COM 220.100, Collateral Approval – South Carolina Department of Health and Human Services defines the reading level of member materials as 6.9 or below, with permissible exclusions, unless SCDHHS makes an exception. The policy does not define the method used to determine reading level of member materials. Onsite discussion confirmed the Flesch – Kincaid method is used to determine readability.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy COM 220.105, The Production of Vital Documents in Alternative Formats confirms materials are available in alternate formats including languages other than English, Braille, large font, audio tapes, and VHS with Closed Captioning. Sight translation (oral interpretation) of information for which written translation is not readily available is provided at the request of the member. *Recommendation: Include the method used to determine readability of member materials in Policy COM 220.100, Collateral Approval – South Carolina Department of Health and Human Services.*
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					The Member Services Call Center is staffed Monday through Friday from 8 a.m. to 9 p.m. and weekends from 8 a.m. to 6 p.m. All holidays except Christmas Day are also covered. Outside of the normal business hours, the Interactive Voice Response (IVR) system instructs to call 911 or go to the nearest Emergency Room (ER) for life-threatening emergencies. The IVR also provides instructions to reach the PCP and the Nurse Help Line, which is available 24-hours-a-day. Callers are given the option to leave a message to which a response is provided within one business day. The toll-free telephone number and the TTY number for the Member Services Call Center are published in the *Member Handbook*. Policy MEM 129.116, Member Services Coverage defines call center performance standards which

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						are compliant with requirements of the *SCDHHS Contract*.
III C. Member Enrollment and Disenrollment						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Member Services staff contact newly enrolled members within 14 days to provide orientation to the health plan and encourage PCP selection. If the contact is unsuccessful, a PCP is assigned to the member using an algorithm that considers other family members with an assigned PCP, location of the PCP in relation to the member, and age and gender appropriateness.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Select Health informs members of available programs and eligibility requirements for participation using methods such as the *Member Handbook*, mailings, newsletters, live and automated calls, text messaging, and its website. Community Health Navigators and Health Educators provide information about programs and services through in-person interactions and information disseminated at community events. Care Management and Contact Center staff are alerted to the member's care gaps so that they may be addressed during member interaction. The Member Portal provides care gap and other

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						personal medical information to members who log onto the portal. Care Gap reports, available via the Provider Portal, identify assigned members who are missing or due for recommended EPDST or other recommended services. The *QI Work Plan for 2018* reflects initiatives to increase women's health screenings, increase receipt of the flu vaccine by high-risk members, increase EPSDT rates, and improve smoking cessation rates.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					The EPSDT Tracking System uses data sources (claims, encounter data, registry data, etc.) to identify EPSDT-eligible members who are missing or due for services. Care Connectors attempt to contact members to remind them about immunizations and screenings due and to assist in scheduling appointments for these services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					Select Health uses seasonal topical mailings, automated calls, text messaging, community events, and the website to inform members about health risk factors and to encourage healthy behaviors.
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					Pregnant members are identified through a variety of means such as welcome calls, eligibility files, prenatal risk assessments, self-referrals, health risk assessments, physician referrals, inter-departmental referrals/coordination, and nurse advice line referrals. Pregnant members are stratified into either low- or high-risk based on identified risk factors. Low-risk

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members are provided educational materials about prenatal care and can discuss questions or concerns with a maternal child Care Manager or Care Connector. High-risk members are followed during the pregnancy by dedicated prenatal nurse Care Managers who contact the member regularly to educate and provide other resources as needed. The CM collaborates with the OB provider and other applicable specialists to coordinate access to additional resources.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Select Health contracts with Morpace, a certified CAHPS survey vendor, to conduct the Adult and Child *Member Satisfaction Surveys*. For both the Adult and Child surveys, response rates for the 2018 surveys are the same as 2017, at 21% and 24% respectively. The Child CCC total sample response rate for 2018 is 26%, which is a slight increase from 2017. NCQA averages for 2017 are 23% for Adult and 22% for Child. Therefore, Select Health is below the Adult national average rate but above the Child national average rate. *Recommendations: Continue working with vendors to increase response rates from 24% for Child and 21% for Adult. These are similar to national averages, though below the NCQA target response rate of 40%.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Morpace summarizes and details all results from Adult and Child surveys. Select Health identifies problem areas in the surveys.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					To address issues identified through the *Member Satisfaction Survey*, Select Health focuses on items that are below standard.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The MCO reports the results of the *Member Satisfaction Survey* to providers. After the Onsite visit, Select Health submitted a special edition of the *Provider Newsletter* that contains the results of the 2018 CAHPS survey.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					After the Onsite visit concluded, the plan submitted QSC minutes from the August 28, 2018 meeting and revealed presentation of the CAHPS results to the committee.
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					Processes and requirements for processing member grievances are found in Policy MMS.100, Member Grievances and Appeals Process.
1.1 The definition of a grievance and who may file a grievance;	X					Appropriate information about the definition of a grievance and who may file a grievance are found in Policy MMS.100, Member Grievances and Appeals Process, the *Member Handbook*, the *Provider Manual*, and the First Choice website.
1.2 Procedures for filing and handling a grievance;		X				Requirements and processes for filing and handling grievances are appropriately documented in Policy MMS.100, the *Member Handbook*, and on the website. The *Provider Manual*, page 50, states grievances can be filed by calling member services. There is no mention that grievances can also be filed in writing or how to complete a written filing. *Quality Improvement Plan: Update page 50 of the Provider Manual to include all methods of filing grievances.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;		X				Documentation of requirements for the timeframes within which grievances must be resolved is present in Policy MMS.100, the *Member Handbook*, the *Provider Manual*, and the First Choice website. Issues with documentation of grievance resolution timeframes include: •Page 50 of the *Provider Manual*, in the third paragraph under the heading "Member Grievances, defines the grievance resolution timeframe as 90 calendar days from the day Select Health receives the grievance; however, the next paragraph (at the bottom of page 50 and continuing to page 51) states, "Select Health is required to investigate these types of grievances (complaints not related to the physical condition of the office) and respond to the member within five business days." Onsite discussion confirmed this information is incorrect. •Information about extensions of grievance resolution timeframes is not found within the "Member Grievances" section (pages 50-51) of the *Provider Manual*. Instead, it is included under a separate heading "Extension of Grievance and Appeal Resolution Time Frames" on pages 37-38 of the *Provider Manual*. The "Member Grievances" section of the *Provider Manual* does not refer the reader to the separate section to obtain additional information. *Quality Improvement Plan: Remove the incorrect information that states Select Health must respond to member grievances within five business days from pages 50-51 of the Provider Manual.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Include information regarding extensions of grievance resolution timeframes in the "Member Grievances" section of the Provider Manual.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					Policy MMS.100, Member Grievances and Appeals Process appropriately defines requirements and qualifications for reviewers of grievances related to clinical issues or denials of expedited appeal resolutions.
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.		X				CCME reviewed twenty grievance files. The files reflect timely resolutions and appropriate reviewers. Issues identified are related to information in the resolution letters. These include: •Letters appear to use pre-formulated, standard verbiage that does not always apply to the resolution of the grievance and that is not corroborated by documentation found in the file. For example, many of the letters state the provider's office was contacted and educated about plan policies; however, there is no indication in the file notes indicating provider education occurred. This is noted in at least five of the files reviewed. •Two grievance resolution letters do not contain enough information for the member to understand how the grievance was resolved. For both files, information is provided to the health plan by the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provider's office that the member needs to know. The letters simply include information such as, "the grievance has been addressed and resolved." *Quality Improvement Plan: In grievance resolution letters, avoid using pre-formulated, standard verbiage that does not apply or does not correspond to the plan's notes documenting the resolution activities. Ensure grievance resolution letters contain enough information for the member to understand what occurred (when possible) to resolve the grievance.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Policy MMS.100, Member Grievances and Appeals Process indicates Select Health presents a summary of all member grievances to the QSC annually. The summary includes an evaluation of grievance activity compared to the previous year and identifies areas for additional review. The results are evaluated along with responses to the annual member satisfaction survey to identify ways to improve member satisfaction. An additional evaluation reviewing the most frequent grievance categories and provider trending is conducted mid-year to identify trends prior to the annual summary report. Results of the mid-year evaluation are also reported to the QSC for evaluation and recommendations. Review of QSC minutes reveals the annual summary report of grievance data for 2017 was to be presented on April 24, 2018 but was tabled due to timing of the Appeals & Grievances Committee meeting. The full summary report was reported during the August 29, 2018 meeting. Opportunities

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for improvement and interventions to achieve improvement were discussed.
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 *2018 QAPI Program Description* describes the program's quality improvement structure, function, scope, and goals as defined by the health plan. The BOD provides strategic direction and ultimate authority and responsibility for the QI Program and approves the Program Description annually. CCME identified a few issues in the Program Description that appear incorrect or confusing. These include: •Page 4 indicates this is the *2017 QAPI Program Description*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Page 9 states the QAPI work plan includes planned monitoring or previously identified issues. This is not found in the work plan. •The Committee Structure on page 10 includes the Culturally and Linguistically Appropriate Services (CLAS) Committee. Onsite Select staff indicate this committee is no longer a committee under Quality. •The designated physician providing clinical expertise for the Quality program is listed as the Regional Chief Medical Director on page 19; however, the Market CMO, Dr. Caton, is responsible for clinical oversight. •Monitoring Continuity and Coordination of Care is listed as one of the QI activities on page 29. The results of this monitoring as described on page 29 is not present. *Recommendation: Update the Quality Assessment and Performance Improvement 2018 Program Description and correct the issues identified.*
2. The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines.	X					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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 BOD has delegated the operational responsibility for the program to Select Health's Market President, Courtnay Thompson, and to the Quality Assessment Performance Improvement Committee (QAPIC). The QAPIC directs and reviews the QI, Utilization Management (UM), and the Integrated Health Care Management activities. Select Health also has several subcommittees of the QAPIC. Those include the Quality of Clinical Care, Quality of Service, Credentialing, and the CLAS Committees.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The membership of the QAPIC and the Quality of Clinical Care (QCC) Committee includes network providers, the health plan's Medical Directors, and regional and local directors. The QI Program Description includes the voting members for the QCC committee as the network providers and the health plan's Medical Directors. The voting members listed in the committee charter and the meeting minutes are inconsistent with the QI Program Description. *Recommendation: Update the list of voting members in the QCC Committee charter, on the minutes, and in the QI Program Description.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The QI Committee meets at regular quarterly intervals.	X					According to the QI Program Description, the QAPIC meets quarterly and the QCC Committee meets bi-monthly or a minimum of five times per year. Select Health did not provide minutes for all of the QCC Committee meetings. CCME received minutes for the meetings held in May 2018 and in July 2018. Select Health staff indicates a meeting was also held in April 2018; however, the meeting was not recorded due to a malfunction of the device. *Recommendation: Ensure the QCC Committee is meeting the required frequency as outlined in the QI Program description and each meeting is documented with committee minutes.*
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are documented for all meetings. Some of the minutes for the QAPIC meetings appear incomplete. The column for discussion on the minutes is blank or did not include the committee's decision. The meetings held in October 2007 and in December 2017 are two examples.
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					Select Health uses Inovalon, a certified software organization for calculation of HEDIS rates. Rates were audited by HealthcareDataCompany, LLC. The comparison from the previous to the current year reveal a strong increase in BMI Percentile Documentation and Follow-Up Care for Children Prescribed ADHD Medication Continuation and Maintenance. The most problematic is Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) for 1- to 5- year-olds, which decreased 20%. Details of the validation of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performance measures (PMs) are found in the *CCME EQR Validation Worksheets, Attachment 3.*
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					Topics include *Diabetes Outcomes Measures* and *Follow-up After Hospitalization for Mental Health Within 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					Both projects score within the High-Confidence range and meet the validation requirements. The *Diabetes Outcomes Measure* PIP documentation does not include actual p-values for proportion comparisons. Details of the validation of the performance projects is found in the *CCME EQR Validation Worksheets, Attachment 3.* *Recommendation: Correct the p-values in the Diabetes Outcomes Measure PIP document.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Specific quality measures are incorporated into the primary care provider's report cards distributed to providers annually.
IV F. Annual Evaluation of the Quality Improvement Program						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Select Health evaluates the effectiveness of its QI Program annually. For this review, the health plan provided the *Quality Assessment Performance Improvement 2017 Program Evaluation*. This report provides a high-level assessment of the results of QI activities conducted in 2017. Confusion exists in some of the analysis of HEDIS measures regarding the reported rate for the calendar year or the analysis indicates there is a reduction in the rate when in fact there is an increase in the reported rate. The report identifies barriers, interventions, and improvement opportunities.
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						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 (UM) Program Description* outlines the goals, objectives, and staff roles for physical and behavioral health (BH) services for members in South Carolina. Several policies, such as UM.008S, Clinical Criteria, UM.003S Standard and Urgent Prior Authorization, and UM.002S Concurrent Review, provide guidance on UM processes and requirements.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					Page 2 of the *UM Program Description* states, the program "concentrates on medical necessity and outcome of treatment, emphasizing prospective and concurrent UM of physical and behavioral health services."
1.2 lines of responsibility and accountability;	X					Lines of responsibility and accountability are appropriately addressed in the *UM Program Description*, indicating Select Health's UM Regional Director, Manager, and Supervisors have oversight of the program. Specific roles and responsibilities of UM staff are captured in job description documents.
1.3 guidelines / standards to be used in making utilization management decisions;	X					Guidelines and standards used to make UM decisions are described in the *UM Program Description* and detailed in Policy UM.008S Clinical Criteria. The QCCC reviews and approves the criteria annually.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for UM decision time frames are described in the *UM Program Description*, *Member Handbook*, and *Provider Manual*. Requirements are also detailed in Policy UM.010S Timeliness of UM Decisions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 consideration of new technology;	X					Consideration of new technology or new uses of existing technologies is addressed in Policy UM.016S Evaluation of New Technology. The policy applies to medical procedures, behavioral health procedures, pharmaceuticals, and devices and is addressed by the Clinical Policy Committee (CPC).
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					The *UM Program Description*, *Provider Manual*, and *Member Handbook* describe that Select Health does not provide additional compensation or incentives to providers or staff for denial of coverage or services. As noted on page 14 in the *UM Program Description*, "All Select Health employees are required to adhere to the Code of Ethics and Conduct" which has a section on "Ensuring Appropriate Services for Members," and is reviewed upon hire and annually thereafter.
1.7 the mechanism to provide for a preferred provider program.	X					Policy UM.318S Preferred Provider Program describes the requirements and the process for providers who perform bariatric surgery, spine surgery and pain management procedures to be considered for the program. During the Onsite, Select Health reported the program was established in 2018 and currently includes bariatric providers. Providers performing pain management and spine procedures will be considered after the program is evaluated.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The *UM Program Description* outlines the responsibilities of the Market CMO and BH UM Medical Director at the plan level. Respectively, Kirt Caton, MD, and Roger Beardmore, MD actively participate on the QAPIC, where UM activities are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviewed and approved. This is reflected in 2017 QAPIC meeting minutes.
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					Annually, Select Health evaluates the UM program for medical and behavioral health services to assess its strengths and effectiveness and makes updates based on findings. The *2017 UM Program Evaluation* was presented and approved by the QCCC April 12, 2018 and by the QAPIC April 30, 2018. The QAPIC provides oversight for the integrated UM program and the QCC is a multidisciplinary group responsible for evaluating clinical and preventive practice guidelines and adoption of utilization review criteria.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Policy UM.008S, Clinical Criteria lists UM standards and criteria used for determining medical necessity. The criteria are evidenced-based and follow nationally recognized UM standards. Select Health uses the following criteria: the *SCDHHS Contract*, *SCDHHS Policy and Procedure Guide*, South Carolina Medicaid Provider Manuals, Corporate Clinical Policies, and InterQual.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					15 UM approval files reflect consistent decision making using criteria and relevant medical information as described in the *UM Program Description* and Policy UM.008S, Clinical Criteria.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Policy UM.312S Hysterectomy and Family Planning. The criteria for utilization are communicated in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member Handbook, the *Provider Manual*, and the Select Health website. The applicable forms are noted correctly in the *Provider Manual*.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Select Health allows for unique patient decisions in UM as noted in Policy UM.008S Clinical Criteria, which describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy UM.708S, Inter-rater Reliability and the *UM Program Description* note inter-rater reliability (IRR) is conducted quarterly for licensed clinical reviewers and twice a year for all physicians. UM clinicians, behavioral health clinicians, and Medical Directors participate in the IRR process. The established benchmark for all test takers is 90%, which is exceeded by all staff individually and as a group, as noted in the *2017 UM Program Evaluation*. Committee minutes indicate IRR results were reported to the QAPIC June 28, 2018. During Onsite discussion, PerformRX confirmed the pharmacy Prior Authorization Team receives clinical quizzes monthly and test case scenarios twice yearly as part of the IRR process. Policy I236.010, Inter-rater Reliability Testing was provided for review.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Formulary restrictions are noted on the *Preferred Drug List* (PDL), which identifies over-the-counter (OTC) medications that are covered with a prescription and those requiring prior authorization.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, the *Pharmacy Prior Authorization Procedure* details specific criteria used for listed medications. Pharmacy benefit information is available in the *Member Handbook* and *Provider Manual*. The PDL and the *Pharmacy Prior Authorization Procedure* are posted on the Select Health website. Committee minutes and the *Provider Manual* reflect PerformRx is the Pharmacy Benefit Manager for Select Health and can be contacted about benefit questions, including eligibility, PDL status, and benefit exclusions or inclusions.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Select Health has a process for making exceptions to the closed formulary based on medical necessity. Policy, 150.400 Pharmacy Benefits and Management indicates a five day supply of medication will be approved while a prior authorization request is pending or a 30 day supply will be approved if additional authorization time is required. Criteria for medication decisions are listed in the Select Health Pharmacy Prior Authorization Procedure document located on the provider tab of the website. During Onsite discussion, Select Health reported the first fill of a specialty medication can be obtained from a local pharmacy if immediate access is required and members are made aware via the *Member Handbook*. CCME was directed to page 19 of the *Member Handbook* that instructs members to call Member Services with questions regarding pharmacy prior authorization. Upon review, CCME could not identify how members can request

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specialty pharmacy medications from a local pharmacy if immediate access is needed. *Recommendation: Edit the Member Handbook to include clear instructions for members to obtain specialty pharmacy medications from a local pharmacy if medical circumstances require more immediate access than is available from the specialty pharmacy as required in SCDHHS Contract, Section 4.2.21.5.*
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy UM.905S, Emergency Room Services appropriately defines an emergency and addresses coverage for post-stabilization services. The *Provider Manual* and *Member Handbook* describe emergency medical services requirements adequately. During the Onsite, Select Health confirmed, when the Code of Federal Regulations (CFR) are referenced in policies or other documents, staff is trained to access the CFR to obtain specific criteria requirements, including whether detailed CFR information is needed.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					The *UM Program Description* and policies, such as, UM.008S, Clinical Criteria and UM.017S, Notice of Adverse Determinations, describe staff who are licensed and trained to perform physical and BH clinical reviews. Additionally, the plan indicates the appropriate Medical Director will render denials and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review cases which the UM staff cannot approve. This process is evident in the approval files CCME reviewed.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization time frames for UM approval files are consistent with the *UM Program Description*, Policy UM.008S, Clinical Criteria, and *SCDHHS Contract* 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					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					12 files for Adverse Benefit Determinations reflect decisions are made by an appropriate physician specialist as outlined in Policy UM.017S, Notice of Adverse Determinations. Dr. Caton, a physician in family medicine, and Dr. Dalal, a psychiatrist, respectively reviewed physical health and behavioral service requests.
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					Denial files reveal denial decisions are made according to the processes described in Policy UM.017S, Notice of Adverse Determinations. Decisions are promptly communicated within 1 day via phone or fax and within 3 days via written letter. Adverse benefit determination letters to the provider and member indicate the criteria used for decision-making, give clear explanations that are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						easily understood, and include clear instructions for the appeal 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 Grievance and Appeals Process and the *UM Program Description* outline the appeals processes for providers and members. The *Provider Manual* and *Member Handbook* provide circumstances and instructions for the appeal process.
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, and who may file an appeal, are described in Policy MMS.100, Member Grievances and Appeals Process, the *Provider Manual*, the *Member Handbook* and the website.
1.2 The procedure for filing an appeal;	X					Instructions for filing an appeal are listed in the *Member Handbook*, *Provider Manual*, Policy MMS.100, Member Grievance and Appeals Process, on the website, and in adverse benefit determination notices. During the Onsite, CCME noted the timeframe for acknowledging a member appeal is not included in the *Member Handbook* or the website. *Recommendation: To have consistent communication with the Provider Manual and policies, include the requirement for acknowledgment of appeals in the Member Handbook and the website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					Requirements for continuation of benefits is clearly described in the *Member Handbook* and the plan website; however, the required language, in *42 CFR section 438.420(a)(i)* and *(ii)*, is omitted from Policy MMS.100, Member Grievance and Appeals Process and the *Provider Manual*. During the Onsite visit, Select Health confirmed that when the *Code of Federal Regulations* (CFR) are referenced in policies or other documents, staff is trained to access the CFR to obtain specific criteria requirements, thus including detailed CFR information is unnecessary. Additionally, applicable letter templates describe requirements for continuation of benefits appropriately.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO applies the appeal policies and procedures as formulated.	X					Review of 20 appeal files reflect the following issues: •File #12 has discrepant receipt dates documented on the acknowledgement letter (10/4/17), resolution letter (10/3/17), and in the Episode Details (10/3/17). •File #16 has inconsistent and confusing documentation, such as indicating the appeal was initially expedited, then downgraded to standard. It was administratively overturned due to BH timeliness to make a decision within 24 hours, and the member was informed of the downgrade and told a decision will be made in 5 days. Onsite discussion revealed the date on the acknowledgement letter in file #12 is an error and the documentation in file #16 is a miscommunication among staff members regarding the timeframe for expedited appeals. *Recommendation: Ensure appeal acknowledgement letters have correct receipt dates and appeals are processed within the appropriate timeframe for the type of request.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The *2017 UM Program Evaluation* and QAPIC meeting minutes reflect member appeals are appropriately categorized, analyzed, and evaluated for improvement opportunities in physical, behavioral health, and pharmacy services. Additionally, the Administrative Appeal and Grievance Committee evaluates appeals data. Onsite discussion confirmed results are reported to the QAPIC annually.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V D. Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					Page 1 of Policy IHCM 201S, Integrated Health Care Management Standard of Practice states, "The Integrated Health Care Management (IHCM) program is a population-based health management program that utilizes a blended model to provide comprehensive Care Management (CM) and Disease Management (DM) services." The IHCM is adequately communicated in the *Provider Manual* the Select Health website, and described briefly in the *Member Handbook*. The *Population Health Management (PHM) Strategy Document* outlines the framework for case management (CM)/care coordination program goals, objectives, lines of responsibility, and operations for physical and behavioral health services. During the Onsite, Select Health reported PHM was implemented in 2018 and the *PHM Strategy Document* replaced the *Integrated Health Management Program Description*. *Recommendation: Include descriptions of available IHCM care management programs in the Member Handbook to be consistent with information described in the Provider Manual and the website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from case management.	X					The *PHM Strategy Document*, Policy IHCM 202S, Referral to IHCM, and the *Provider Manual* describe various methods for identifying and referring eligible members to CM, such as: medical, behavioral health and pharmacy claims, laboratory and health risk assessment results, medical records, and UM data. Identified members are segmented into population subsets for targeted interventions that are stratified into low-risk, moderate-risk, and high-risk categories.
3. The MCO provides care management activities based on the member's risk stratification.	X					Select Health provides care management activities based on member risk stratification as described in the *PHM Strategy Document* under the "Targeted Population Subsets and Interventions" section.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Policy IHCM 301S, MCO Transition Coordinator defines the role and responsibilities of the Transition Coordinator. During the Onsite, Select Health confirmed Susan Lewis-Rumbold is the Transition Coordinator.
6. The MCO measures case management performance and member satisfaction and has processes to improve performance when necessary.	X					The *IHCM Program Evaluation* describes the purpose and process used to measure CM effectiveness and member satisfaction. The information obtained from the annual surveys is used to assess strengths and weaknesses to improve Case Management and Disease Management Programs. The Program Evaluation indicates member satisfaction goals were not met in 2017. The QCCC evaluates results of the IHCM Program and reviews data from member satisfaction survey reports. During the Onsite visit, Select Health explained the IHCM Program Evaluation is reported to the QCCC and the minutes are in draft and unavailable for review.
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate care management activities are conducted as required, and Case Managers follow policies to conduct the appropriate level of CM. HIPAA verification and identifying care-gaps are addressed consistently. Unable to contact (UTC) letters and education materials are used appropriately.

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-utilization and over-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					Select Health analyzes and monitors data and offers recommendations based on findings about utilization 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 contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.		X				Select Health ensures all delegation arrangements are governed by written agreements between the delegate and the plan through a *Delegation Agreement* that outlines the scope of the delegated activities, reporting responsibilities, the responsibilities of the plan, stakeholder departments, and the delegated entity performance monitoring process. Corporate Policy 277.010, Delegation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Oversight defines the procedures for pre-delegation assessment of delegate capabilities along with annual oversight of delegate performance. Credentialing and recredentialing delegated processes are addressed in Policy CR.101.SC, Delegation of Credentialing and Recredentialing. Attachment F, 2018 South Carolina/Medicaid Credentialing Requirements contains *2016 SCDHHS Contract* and *SCDHHS Policy and Procedure Guide* references that are outdated, and the information does not match the tool used for annual oversight which appears to be updated. *Quality Improvement Plan: Ensure Attachment F of Policy CR.101.SC, Delegation of Credentialing and Recredentialing, is updated to reflect the current SCDHHS Contract and SCDHHS Policy and Procedure Guide references.*
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Evidence of annual oversight review was received for all delegated entities. It was confirmed during the Onsite review that BHM Healthcare Solutions is a new delegation and the plan provided proof of the pre-delegation audit. Select Health uses an NCQA tool and a South Carolina specific tool, when applicable. Oversight tools are comprehensive and appropriate.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					As a component of EPSDT requirements, Select Health ensures pediatric and adolescent immunization requirements are monitored as described in Policies QI 154.006, EPSDT/Prevention and Screening Outreach and QI 154.009, Medical Record Review. HEDIS reports in the *2017 Quality Assessment and Performance Improvement Program Evaluation* details how child and adolescent immunizations are tracked, monitored, and evaluated for improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					Select Health follows the EPSDT schedule for members through 21 years of age. The plan monitors provider compliance with providing EPSDT services via medical record reviews as noted in Policy QI 154.009, Medical Record Review. In addition to the *Provider Manual*, Policy QI 154.006, EPSDT/Prevention and Screening Outreach and the *PHM Strategy* document, list several methods used to inform and remind providers of impending or missed EPSDT services, such as: •Notifying providers when specific members are due for EPSDT visits •Reviewing care gap lists with providers •Posting on the Navinet provider portal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						HEDIS reports and review of provider claims are additional methods used for monitoring EPSDT compliance.
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					