South Carolina
Medicaid Quality Strategy
2022

Contents

Introduction and History

This Quality Strategy document is a technical document required by the Code of Federal Regulations, CFR 438.340, and the Centers for Medicare and Medicaid Services (CMS) programs to ensure the delivery of quality health care. This Quality Strategy will outline the Managed Care Organizations (MCOs) goals and objectives, as well as highlight other programs and initiatives that are intended to support the improvement of health outcomes for Medicaid membership. SCDHHS has reviewed and assessed the implementation of the 2019 Managed Care Organization Quality Strategy and has used this analysis as well as CMS feedback to the State to inform the approach to the 2022 Quality Strategy. SCDHHS, to align quality across the Agency, has elected to build a full Bureau of Quality that will serve as a central source of quality standards and practices. A description of the Bureau and Offices can be found in the Quality Management section of this document.

The South Carolina Department of Health and Human Services (SCDHHS) is the single state agency designated to administer South Carolina's Medicaid program under Title XIX of the Social Security Act. SCDHHS' mission is to purchase the most health for our citizens in need at the least possible cost to the taxpayer. In 1994, South Carolina Governor Carroll Campbell initiated the Palmetto Health Initiative, a statewide research and demonstration project which included restructuring the fee-for-service delivery system into a managed care delivery system. In 1996, South Carolina began operating a comprehensive risk-based managed care organization (MCO) program, which served certain children, pregnant women, and non-dual eligible adults with disabilities, and covered acute, primary and some specialty care services and outpatient behavioral health. Initially, MCOs were available on a voluntary basis.

Between 2006 and 2007, SCDHHS introduced the Medical Homes Network (MHN) program, a statewide Enhanced Primary Care Case Management program (PCCM), that utilized networks of primary care providers to provide and arrange for most Medicaid acute, primary and specialty care and behavioral health for eligible Medicaid participants (excluding those in another managed care program, receiving home and community-based waiver services or residing in an institution). In Sept. 2013, SCDHHS transitioned from the PCCM program to an MCO service delivery system. Enrollment in the managed care program remained limited until 2006, when SCDHHS introduced the Healthy Connections Program.

In 2011, SCDHHS further expanded Healthy Connections through mandatory enrollment of Medicaid beneficiaries formerly served in the Fee-For-Service (FFS) system. Children in Foster Care and with certain disabilities, Medicaid waiver enrollees, certain people served in institutions and dual-eligible beneficiaries remained exempt from mandatory participation in managed care. In October 2013, SCDHHS expanded mandatory enrollment in managed care to all children under the age of one, and In July 2016, SCDHHS "carved-in" inpatient Behavioral Health Services to the MCO benefit package.

Commented [JT1]: First time this acronym is used in the document you might want to spell it out here. I realize you do it in the second paragraph as well so just a potential suggestion.

Commented [JT2]: I think the way this is worded is fine. I just want you to know that the Medically Complex program has a PCCM component to it that the agency still operates today which I am not positive we should be doing at least not in the way we currently do it. I am bringing this up because if CMS starts crosschecking against the state plan you may get questions about this paragraph.

Populations Served

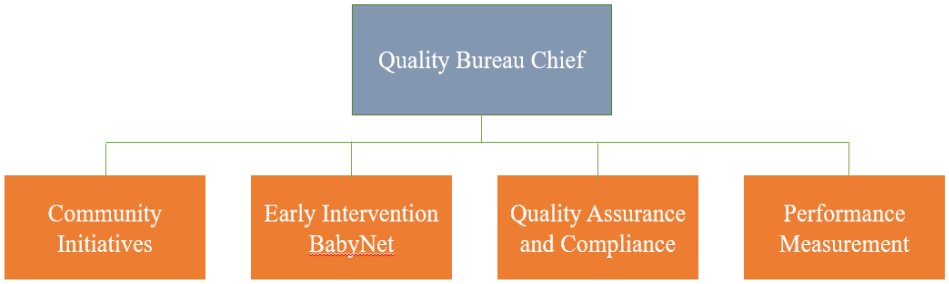
Plan Name	MCP Type	Managed Care Authority	Populations Served
Managed Care Organizations			
Absolute Total Care	MCO	1932(a)	TANF Populations under age 65; Non-Dual, Non HCBS Waiver
BlueChoice Health plan	MCO	1932(a)	TANF Populations under age 65; Non-Dual, Non HCBS Waiver
Humana Benefit Plan	MCO	1932(a)	TANF Populations under age 65; Non-Dual, Non HCBS Waiver
Molina Healthcare	MCO	1932(a)	TANF Populations under age 65; Non-Dual, Non HCBS Waiver
Select Health (First Choice)	MCO	1932(a)	TANF Populations under age 65; Non-Dual, Non HCBS Waiver
Healthy Connections PRIME Medicare-Medicaid Plan			
Absolute Total Care	MMP	Financial Alignment Initiative/Dual Demonstration Grant (1115)	Dual Medicare/Medicaid over the age of 65
Select Health (First Choice)	MMP	Financial Alignment Initiative/Dual Demonstration Grant (1115)	Dual Medicare/Medicaid over the age of 65
Molina Healthcare	MMP	Financial Alignment Initiative/Dual Demonstration Grant (1115)	Dual Medicare/Medicaid over the age of 65
Dual-Eligible Special Needs Plan (D-SNP)			
Absolute Total Care	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)

Arcadian Health/Humana Insurance Co.	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)
EON Health	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)
Harmony Health Plan, Inc.	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)
Molina Healthcare	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)
United Healthcare Insurance Company of America	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)
Wellcare of South Carolina, Inc	D-SNP	MOA	Qualified Medicaid Beneficiary, Qualified Medicaid Beneficiary plus (+), Full Benefit Dual Eligible (FBDE)
Waivers			
Medically Complex Children's (MCC) Waiver	Waiver	1915 (c)	Medicaid eligible, under age 18, meets medical criteria and At-Risk of Hospitalization level of care
Community Choices Waiver	Waiver	1915 (c)	Medicaid eligible, age 18 or older, and meets Nursing Facility level of care
Community Supports (CS) Waiver	Waiver	1915 (c)	Medicaid eligible, all ages, with intellectual or related disability, and meets ICF/IID level of care
Head & Spinal Cord Injury (HASCI) Waiver	Waiver	1915 (c)	Medicaid eligible, age 0-65, with head or spinal cord injury, or similar disability, and meets Nursing Facility or ICF/IID level of care

HIV/AIDS Waiver	Waiver	1915 (c)	Medicaid eligible, any age, diagnosed with HIV/AIDS, and meets At-Risk of Hospitalization level of care
Intellectual Disability/Related Disabilities (ID/RD) Waiver	Waiver	1915 (c)	Medicaid eligible, all ages, with intellectual or related disability, and meets ICF/IID level of care
Mechanical Ventilator Waiver	Waiver	1915 (c)	Medicaid eligible, age 21 or older, requires life sustaining mechanical ventilation at least 6 hours/day, and meets Nursing Facility level of care
Palmetto Coordinated Systems of Care	Waiver	1915 (c)	Medicaid eligible, age 18 or older, and meets Nursing Facility level of care

Quality Strategy Management

The Bureau of Quality is responsible for development and management of the Quality Strategy. The Bureau of Quality includes the following offices:



Office of Community Initiatives

This Office is responsible for the administration and oversight of quality-based community activities. Office assumes accountability for managing projects that advance comprehensive community initiatives that serve the Medicaid member population and beyond. This includes designing and deploying

a range of capacity-building resources including technical assistance, training, and collective impact models. Current projects include:

- The Quality through Technology and Innovation in Pediatrics (Q-TIP) program works to improve health care for children in South Carolina by working on quality measures and incorporating mental health into a medical home. Started in 2010 under a CHIPRA federal grant, this program brings pediatric practices together to collaborate on specific measures to foster quality improvement projects at each practice site. QTIP represents a unique opportunity for South Carolina pediatricians to help develop quality improvement tools that will lead to better health outcomes for current and future generations of patients. Currently 29 pediatric practices across the state are engaged with QTIP.
- The South Carolina Birth Outcomes Initiative (BOI) was established in 2011 as a collaborative of SCDHHS, the South Carolina Department of Health and Environmental Control (DHEC), South Carolina Hospital Association, March of Dimes, BlueCross BlueShield of South Carolina (BCBSSC) and more than 100 stakeholders. SCBOI's overall goals are to improve health outcomes in both moms and babies throughout SC. SCBOI leverages the collective impact model to identify a common agenda and provide for continuous communication.

Office of BabyNet

SCDHHS operates predominantly as the designated single state agency for the Title XIX Medicaid program and Title XXI Children's Health Insurance program but administers several other state and federal human service programs. On July 1, 2017, SCDHHS assumed lead agency designation for South Carolina's Individuals with Disabilities Education Act (IDEA) Part C program, which partially finances services for infants and toddlers with developmental delays up to their third birthday.

South Carolina's IDEA Part C program, known as "BabyNet," engaged in a cooperative corrective action plan, granted funds under special conditions, participated in intensive differentiated monitoring and oversight by the United States Department of Education (DOEd) Office of Special Education Programs (OSEP), and engaged with technical assistance providers. Since the lead agency change, most of SCDHHS' efforts to bring its IDEA Part C program into federal compliance have been focused on systems and staff integration with other SCDHHS programs, reevaluating assumptions, policies, program designs, reducing reliance on low-performing vendors and providers, and assuming greater control over data and analysis to identify and correct system deficiencies. Further, the department has revised or entirely restarted efforts that are inconsistent with the program's core goals of timely identification, assessment, and referral to services of children aged 0 – 3 with developmental delays.

Office of Quality Assurance and Compliance

The Office of Quality Assurance and Compliance assumes accountability for ensuring that quality assurance and performance improvement is defined, implemented, and given a high priority in the overall management of the Agency. The office must also measure program effectiveness while recommending and implementing policies, standards, and procedures that impact maintaining the quality of programs/services that improve member health. The Director of the office works closely with internal and external stakeholders, including government and private sector entities to accomplish the Agency mission. The Office is responsible for developing an Agency-wide QAPI plan and dashboard to include waiver

services, behavioral health, managed care, fee for service, and telehealth monitoring and fosters an Agency-wide commitment to quality assurance.

Performance Measurement Section

This section directs and manages the managed care quality review unit and researches and proposes new activities. In collaboration with the Quality Bureau Chief, this section focuses on development and operations and will facilitate communication with MCOs and SCDHHS medical director and other clinical staff on matters related to quality and population health. This section manages the relationship with the External Quality Review Organization (EQRO) vendor and ensures that all contractual deliverables are met. Led by the Quality Metrics Manager, this section is responsible for oversight and SCDHHS representation in all External Quality Review (EQR) activities and managing all corrective action with each MCO. Additionally, this section is responsible for keeping the Bureau up to date on state and federal guidance related to quality activities as well as best practice standards, measures, programs, and accreditation established by the National Committee for Quality Assurance (NCQA) and other accrediting bodies.

Managed Care Quality Goals and Objectives

Quality Goal 1: Assure the quality and appropriateness of care delivered to members enrolled in managed care

Quality Goal 2: Assure Medicaid members have access to care and a quality experience of care

Quality Goal 3: Assure MCO contract compliance

Quality Goal 4: Manage continuous performance improvement.

Quality Goal 5: Conduct targeted population quality activities.

Objective	Objective Description	Quality Measure	Performance Baseline	Performance Target
Quality Goal 1: Assure the quality and appropriateness of care delivered to members enrolled in managed care				
1.1	Introduce MCO withhold metric ensuring annual preventive care measure rates are equal to or higher than the 50th percentile (3 out of 5) of the National Medicaid managed care health plan rates.	NCQA HEDIS prevention metrics included in health plan ratings.	Absolute Total Care: 3 (2021) Healthy Blue: 2.5 (2021) Molina: 3 (2021) Select Heath: 3.5 (2021) Humana: TBD (2021)	Prevention score of 3 or above
1.2	Introduce MCO withhold metric	NCQA HEDIS treatment metrics	Absolute Total Care: 2.5 (2021)	Treatment score of 3 or above

	ensuring annual treatment measure rates are equal to or higher than the 50th percentile (3 out of 5) of the National Medicaid managed care health plan rates.	included in health plan ratings.	Healthy Blue: 2.5 (2021) Molina: 3 (2021) Select Heath: 2.5 (2021) Humana: TBD (2021)	
1.3	Ensure each MCO has achieved NCQA Health Plan Accreditation	NCQA Health Plan Accreditation	Condition for participation	Condition for participation
Quality Goal 2: Assure Medicaid Members have access to care and a quality experience of care				
2.1	Ensure that the MCO provider networks meet the 90% standard of time or distance.	**Availability**: Provider to Member ratios **Accessibility:** Distance to care, Drive time to care **Accommodation:** Number of providers with extended office hours, Number speaking language other than English **Realized Access:** Utilization of services (HEDIS)	All plans meet each threshold target	All plans meet each threshold target
2.2	Ensure MCO access performance measures do not indicate an access issue	Quarterly review of measures designed to evaluate beneficiary needs as well as utilization: -Grievances and appeals Service utilization -ED visits for conditions treatable in primary care -Member requests for PC and specialists -Member experience of care surveys	Control limits based on historical trends.	Evaluation and management
2.3	Ensure that annual member experience	NCQA Quality Health Plan Patient	Absolute Total Care: 4.5 (2021)	Maintain 2021 ratings

	survey of care rates are equal to or higher than the national average for Medicaid managed care health plans	Experience Ratings, CAHPS data	Healthy Blue: 4 (2021) Molina: 4 (2021) Select Health: 4.5 (2021)	
2.4	Utilize state directed payment arrangement to incentivize hospital quality	Standardized hospital quality metrics defined by stakeholders	Alignment of hospitals into a tiered payment structure to provide an additional uniform dollar payment based on utilization and quality metrics for each Medicaid managed care participant accessing hospital services.	Evaluate and manage hospital movement through tiered quality based uniform payments.
2.5	Utilize state directed payment arrangement to incentivize involvement in medical education programs	Claims data on new patients as well as physician survey	Previously had claims data, now specifying new patient visits and conducting survey of teaching physicians to study retention efforts	Evaluate and manage claims data as well as develop goals and objectives following survey results
2.6	Ensure each MCO has achieved NCQA Health Equity Accreditation	NCQA Health Equity Accreditation	New accreditation	100% MCO accreditation by 2024
Quality Goal 3: Assure MCO Contract Compliance				
3.1	Ensure annual EQRO contract compliance audit results demonstrate MCO contract standards are being met, and for those standards that are not met, corrective action plans take place	EQRO annual on-site compliance review	Evaluation and management	Evaluation and management
Quality Goal 4: Manage Continuous Performance Improvement				
4.1	Ensure that MCO performance improvement projects demonstrate sustained improvement	Review PIPs with each plan to ensure they achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.	Inclusion in EQR	Data support and collaborative process between SCDHHS and MCO

Commented [JT3]: The contract language says must be accredited in 2023. Do you want to amend this a bit to say by January 1, 2024 or by 12/31/2023

4.2	Development of unifying focus project shared by all MCOs	Target project proposed by the Postpartum Learning Collaborative	N/A	Collaborate to develop with target 2023 implementation
4.3	Ensure that annual EQRO technical report includes MCO recommendations for performance improvement	CMS protocols found in 42 CFR 438.364	Complete	Monitor and Evaluation
Quality Goal 5: Conduct Targeted Population Quality Activities				
5.1	Leverage Quality Through Technology and Innovation in Pediatrics (QTIP) practice data and best practices to scale to broader MCO and FFS population	QTIP data and best practice outcomes/measures	N/A	Develop strategy for knowledge sharing and collaboration
5.2	Increase the quantity and improve the quality of postpartum care visits by 15% by the year 2026	Leveraging Postpartum Learning Collaborative to achieve results through unified MCO focus study	Statewide baseline PPV rate of 67%	Statewide PPV rate of 82%
5.3	Monitor and evaluate MMP federal withhold metrics	Federal withhold metrics	All plans meet each threshold target	All plans meet each threshold target
5.4	Develop targeted quality activities focused on behavioral health	Initiate psychiatric residential treatment facility (PRTF) MCO report	Complete	Monitor and Evaluation

Quality of Care

Metrics Used in Quality Goals and Objectives

Objective	Objective Description	Quality Measure	Metrics
Quality Goal 1: Assure the quality and appropriateness of care delivered to members enrolled in managed care			
1.1	Introduce MCO withhold metric ensuring annual preventive care measure rates are equal to or higher than the 50th percentile (3 out of 5) of the National Medicaid managed care health plan rates.	NCQA HEDIS prevention metrics included in health plan ratings.	NCQA 2022 HEDIS Prevention composite measure list including: ADV, CIS, IMA, WCC, PPC, PRS-E, BCS, CCS, CHL, FVA, MSC

1.2	Introduce MCO withhold metric ensuring annual treatment measure rates are equal to or higher than the 50th percentile (3 out of 5) of the National Medicaid managed care health plan rates.	NCQA HEDIS treatment metrics included in health plan ratings.	NCQA 2022 HEDIS Treatment composite measure list including: AMR, CWP, URI, AAB, PCE, CDC, SPD, SPC, CBP, FUH, FUM, FUA, FUI, SAA, AMM, POD, APM, ADD, SSD, APP, IET, PCR, HDO UOP, COU, LBP
1.3	Ensure each MCO has achieved NCQA Health Plan Accreditation	NCQA Health Plan Accreditation	NCQA Health Plan Accreditation survey
Quality Goal 2: Assure Medicaid Members have access to care and a quality experience of care			
2.1	Ensure that the MCO provider networks meet the 90% standard of time or distance.	**Availability**: Provider to Member ratios **Accessibility:** Distance to care, Drive time to care **Accommodation:** Number of providers with extended office hours, Number speaking language other than English **Realized Access:** Utilization of services (HEDIS)	
2.2	Ensure MCO access performance measures do not indicate an access issue	Quarterly review of measures designed to evaluate beneficiary needs as well as utilization: -Grievances and appeals Service utilization -ED visits for conditions treatable in primary care -Member requests for PC and specialists -Member experience of care surveys	IFS Failure Severity Index
2.3	Ensure that annual member experience survey of care rates are equal to or higher than the national average for Medicaid managed care health plans	NCQA Quality Health Plan Patient Experience Ratings, CAHPS data	NCQA 2022 CAHPS composite measure list including: Getting care easily, Getting care quickly, Rating of primary care doctor, Rating of specialist, Coordination of care, Rating of health plan, Rating of care

2.4	Utilize state directed payment arrangement to incentivize hospital quality	Standardized hospital quality metrics defined by stakeholders	In development
2.5	Utilize state directed payment arrangement to incentivize involvement in medical education programs	Claims data on new patients as well as physician survey	In development
2.6	Ensure each MCO has achieved NCQA Health Equity Accreditation	NCQA Health Equity Accreditation	NCQA scoring methodology
Quality Goal 3: Assure MCO Contract Compliance			
3.1	Ensure annual EQRO contract compliance audit results demonstrate MCO contract standards are being met, and for those standards that are not met, corrective action plans take place	EQRO annual on-site compliance review	Federal EQR requirements and ad hoc studies
Quality Goal 4: Manage Continuous Performance Improvement			
4.1	Ensure that MCO performance improvement projects demonstrate sustained improvement	Review PIPs with each plan to ensure they achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical and nonclinical areas.	EQR review
4.2	Development of unifying focus project shared by all MCOs	Target project proposed by the Postpartum Learning Collaborative	In development
4.3	Ensure that annual EQRO technical report includes MCO recommendations for performance improvement	CMS protocols found in 42 CFR 438.364	EQRO recommendations
Quality Goal 5: Conduct Targeted Population Quality Activities			
5.1	Leverage Quality Through Technology and Innovation in Pediatrics (QTIP) practice data and best practices to scale to broader MCO and FFS population	QTIP data and best practice outcomes/measures	In development
5.2	Increase the quantity and improve the quality of postpartum care visits by 15% by the year 2026	Leveraging Postpartum Learning Collaborative to achieve results through unified MCO focus study	In development

5.3	Monitor and evaluate MMP federal withhold metrics	Federal withhold metrics	CMS Medicare-Medicaid Plan Quality Ratings
5.4	Develop targeted quality activities focused on behavioral health	MCO report submission	In development

Public Posting of Quality Measures and Performance Outcomes

SCDHHS is currently redesigning its website and plans to enhance public offerings of quality data. In addition to all EQR reports, SCDHHS plans to share a QAPI dashboard that outlines the above goals and initiatives. Annually, SCDHHS will report on HEDIS measures as well as CMS Child and Adult Core sets.

PIPs and PIP Interventions

Each MCO is contractually required to develop and manage two PIPs that are evaluated annually through the EQR process. In addition to these initiatives, SCDHHS has engaged each MCO in a shared focus study in alignment with the Agency goal of increasing the quantity and improving the quality of postpartum care visits by 15% by the year 2026. SCDHHS and the BOI Access and Coordination workgroup were selected to participate in a CMS/Mathematica collaboration with eight other states in a 12-month quality improvement initiative to improve postpartum care. This collaborative was identified for the first MCO shared focus study to optimize the health of women and infants. In 2020, Medicaid paid for 78% of all emergency department visits and 75% of all inpatient stays during the year prior to and after delivery. The workgroup has identified three primary drivers for change including redefining the postpartum visit, beneficiary engagement, and hospital engagement. Currently the workgroup is using plan, do, study, act (PDSA) cycles to explore change ideas and engage with each MCO on current efforts towards this aligned goal. Specific PIP interventions are forthcoming.

Transition of Care Policy

In accordance with 42 CFR 438.340 (b)(5), each MCO is contractually obligated to develop and implement policies and procedures to address transition of care consistent with the Managed Care Policy and Procedure Guide for new Members, Members who transition between MCOs, Members who transition from Medicaid FFS, and Members still enrolled upon termination or expiration of the contract. Each MCO must designate a person with appropriate training and experience to act as the transition coordinator. This staff person must interact closely with the Department's staff and staff from other MCOs to ensure a safe and orderly transition. Each MCO's Health Plan must also assist the Member with requesting copies of the Member's Health Records from treating providers unless the member has arranged for the transfer. Transfer of records must not interfere or cause delay in providing services to the Member.

When relinquishing Medicaid Managed Care Members, the MCO must cooperate with the Department and new treating providers regarding the course of ongoing care with a specialist or other provider. The relinquishing MCO is responsible for providing timely notification and

needed information to the Department regarding pertinent information related to any special needs of transitioning members, if requested. Such information includes but is not limited to provision of any transitioning Member forms required by the Department, information regarding historical claims paid, and information regarding currently authorized services. In addition to ensuring appropriate referrals, monitoring, and follow-up to providers within the network, the MCO ensures appropriate linkage and interaction with providers outside the network.

Each MCO is responsible for the cost of the continuation of services to newly enrolled Medicaid Managed Care Members entering the MCO's Health Plan. Each MCO must continue authorized services without requiring Prior Authorization for up to ninety (90) Days, continue authorized services regardless of if the service is provided by an in-network or out of network provider or until the MCO has performed appropriate clinical review(s) and arranged for the provision of medically necessary services without disruption. While each MCO may require prior authorization for continuation of services beyond ninety (90) days, the MCO is prohibited from denying authorization solely on the basis that the provider is out-of-network.

For a Member who is in an inpatient hospital setting at the time of enrollment in the MCO's Health Plan, the member's facility charges shall be the responsibility of the payor at admission. Each MCO must provide transition of care for Members who are pregnant or receiving inpatient care. This requirement applies to furnishing core benefits and services in accordance with medical necessity and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries up to the limits as specified in the Medicaid FFS Program as defined in the State Plan, administrative rule and Medicaid Managed Care Policy and Procedure Guide.

For Members entering the MCO's Health Plan in the first or second trimester of pregnancy who are receiving medically necessary covered prenatal care services the day before enrollment, the MCO is responsible for the costs of continuation of such medically necessary prenatal care services. The MCO provides these services without any form of prior approval and without regard to whether such services are being provided by a contracted or out-of-network provider until the MCO can reasonably transfer the Member to a network provider without impeding service delivery that, if not provided, might be harmful to the Member's health. For Members entering the MCO's Health Plan in the third trimester of pregnancy who is receiving medically necessary covered prenatal care services the day before enrollment, the MCO is responsible for the costs of continuation of such medically necessary prenatal care services without any form of prior approval and without regard to whether such services are being provided by a contracted or out of network provider.

In accordance with 42 CFR 430.10(f)(5), the MCO must make a good faith effort to give written notice of termination of a contracted provider for each Member who received his or her primary care from or was seen on a regular basis by the terminated provider. Notice to the Member must be provided by the later of thirty (30) calendar days prior to the effective date of the termination, or fifteen (15) calendar days after receipt or issuance of the termination notice. Each MCO must also ensure the continuation of the Member's benefits/services while an appeal is in process if all contractual conditions are satisfied and consistent with Federal Regulations.

Disparities Plan

SCDHHS has convened an interagency workgroup to develop a comprehensive quality of care health disparities plan. This plan will address and standardize the disparity identification and evaluation method, beneficiary and provider outreach, and stratification of quality metrics by eligibility and enrollment demographic data. SCDHHS will review factors such as age, race, ethnicity, sex, primary language, and disability status to identify and use measures that pertain to health care conditions and/or Medicaid population marked by a high degree of health disparities. In collaboration with key stakeholders, beneficiaries, communities, and agencies, SCDHHS hopes to capture targeted meaningful interventions to address health inequities.

Currently two major projects have been initiated. SCDHHS added a contract amendment for each MCO requiring NCQA Health Equity Accreditation (HE) status in calendar year 2023. NCQA, HE measures health plans on organizational readiness, stratified data collection, access and availability of language services, practitioner network cultural responsiveness, culturally and linguistically appropriate services programs, and reducing health care disparities. In addition to requiring NCQA HE, SCDHHS has joined a stakeholder coalition working to address social determinants of health (SDoH). This workgroup is developing pilots to test value-based payment models that align financial incentives/investments for addressing SDoH, implementing a communications plan to advocate for adoption of shared SDoH definitions and shared goals, as well as accelerating policy and systems solutions that advance shared goals for priority social conditions and populations.

Identification of persons who need LTSS or persons with special health care needs

SCDHHS contractually requires MCOs to conduct an initial screen of each member's needs within ninety days of the effective date of member enrollment. MCOs must utilize appropriate tools and health care professionals in assessing a member's physical and behavioral health needs as well as developing a programmatic-level policies and procedures guide for care management and coordination of services. SCDHHS requires the use of care management and coordination as a continuous process for the assessment of a member's physical health, behavioral health and social support service and assistance needs as well as the identification of persons who need LTSS or persons with special health care needs. SCDHHS requires MCOs to describe its mechanisms to identify persons who need LTSS or persons with special health care needs. MCOS must also describe its mechanisms to assure timely access to and provision, coordination and monitoring of the identified services associated with physical health, behavioral health, LTSS, special needs, and social support services and assistance to help the member maintain or improve his or her health status including coordinating access to services not covered by the MCO plan.

Monitoring and Compliance

Network Adequacy and Availability of Services

In addition to EQRO activities, SCDHHS conducts provider network submission assessments for each MCO plan. Each plan must provide a network submission that reflects all active South Carolina Medicaid network providers. Reviewed quarterly, these submissions are evaluated on the failure severity

index report for network adequacy utilizing a weighted scale of final failure severity from low to high. This failure severity index report produces an overall weighted score in the areas of Provider specialty, Member Eligibility category and County, Member threshold mileage, and time. The weighted results are then categorized into 4 severity categories of low, mid-low, mid-high, and high for the MCO's final failure severity ranking. For all mid-high and high network failures found on the report the MCO's response to SCDHHS must include a plan of action for addressing the assessment failure.

Clinical Practice Guidelines

SCDHHS maintains twenty-six provider manuals in accordance with the State Plan. These manuals are available to the public at Provider Manual List | SC DHHS.

External Quality Review Arrangements

In addition to the goals and objectives outlined above, the contract between SCDHHS and the Carolinas Center for Medical Excellence (CCME) requires an annual comprehensive review of each MCO contracted with SCDHHS. Each external quality review addresses the federal requirements and includes the following components:

- Validation of performance improvement projects conducted by the health plan during the preceding 12 months:
  - Validation of performance measures.
  - Compliance review to determine the health plan's compliance with federal and Medicaid contractual requirements.
- CCME's process, materials, and worksheets follow the CMS protocol and include:
  - Desk review of materials submitted by the health plans.
  - Telephone access study and secret shopper.
  - Onsite visit at each health plan's office.
  - Annual technical report.
  - Review of quality improvement plans for health plans failing to meet any standards.
  - Technical assistance and education as needed.

Each annual review focuses on the health plan's structure and operation, enrollee rights and protections, access to care, MCO quality measurement and improvements. The review also focuses on any deficiencies identified during a previous review to ensure corrections were made and recommendations followed. As part of each health plan's annual review, CCME conducts telephonic provider access studies to ensure compliance with service access standards as specified in the federal regulations and SCDHHS' MCO contracts. The survey questions address correct provider information, appointment availability, scheduling, and member access to providers. CCME requests an electronic list of providers in the desk materials for the EQR. A population of primary care providers is derived from this list. Sample size is calculated based on the population size, and then a sample of providers is drawn. A CCME-developed access study tool is used to standardize the data collection process across health plans. CCME staff members place calls to the practices and ask a series of questions to assess whether the practices accept Medicaid beneficiaries and members from the health plan; whether members have access to appointments within a specified time period; and if providers are screening patients before accepting them into the practice. Results are analyzed and summarized in the annual technical report. The study is

also discussed during the onsite review. In addition, a comparison of the study results for each health plan is included in the annual comprehensive technical report.

Additionally, SCDHHS requires the following reports from the MCOs to ensure they are operating effectively with both their provider networks and their Medicaid membership.

Additional MCO Reporting Used to Assess Compliance with Federal Regulations		
Report Name	**Description**	**Report Timing**
Call Center Performance	Call center performance metrics for member English line, member Spanish language line, and provider call center	Monthly
Encounter Quality Initiative Report	A report detailing the units and amount paid per rate category, utilized to assess encounter completeness and accuracy	Quarterly
Care Management	Report of members receiving care management services on an ongoing basis with the MCO	Monthly
Claims Payment Accuracy	A report detailing totals for monthly claims paid, accepted encounters, rejected encounters and completeness percentage	Monthly
Consumer Assessment of Healthcare Providers and Systems (CAHPS)-Member Satisfaction	A report used for collecting standardized information on enrollee's experiences with health plans and their services. The report identifies strengths and weaknesses of health plans and target areas for improvement	Annual
Healthcare Effectiveness Data and Information Set (HEDIS)	Annual report that shows where improvements can be made within the MCOs for the betterment of the member population	Annual
MCO Fraud and Abuse	Monthly reporting of potential provider and member ongoing fraud and abuse cases	Monthly
Member Grievance and Appeal log	Member grievance and appeal reporting by MCO.	Quarterly/Annually
Provider Dispute Log	Provider dispute reporting by MCO	Quarterly
Termination Denial for Cause	Monthly reporting of any MCO terminated providers	Monthly
Quarterly MCO Fraud and Abuse	Quarterly reporting of potential MCO fraud and abuse cases	Quarterly

Public Comment

To be added