2023 External Quality Review

HEALTHY BLUE OF SOUTH CAROLINA

Submitted: July 20, 2023

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

Table of Contents

EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2023 External Quality Review (EQR) that The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Healthy Blue of South Carolina (Healthy Blue) since the 2022 Annual Review.

The goals and objectives of the review are to:

- Determine if Healthy Blue is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2022 annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

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

Summary and Overall Findings

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

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess Healthy Blue's compliance with the 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

Administration:

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

Healthy Blue partners with Amerigroup Partnership Plan, LLC (Amerigroup) to support its Medicaid line of business. Both Healthy Blue and Amerigroup have policies and procedures in place to ensure quality business operations. The Compliance Committee oversees the annual review of policies for each business unit. The policies are stored in a shared network drive for employee access.

Appropriate personnel and key positions are in place to ensure SCDHHS-required health services are provided to members.

The Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan provides details regarding the establishment and maintenance of ethical standards for business operations. Standards of ethical practices are detailed in the Our Values Code of Conduct document. All employees complete the Compliance Challenge course at hire and annually thereafter. This training covers ethics and the code of conduct; HIPAA privacy and security; and fraud, waste, and abuse (including The False Claims Act and other relevant legislation). Lines of communication are available to report fraud, waste, abuse, criminal activity, conflicts of interest, and breaches of ethical business conduct standards.

The Compliance Plan and Policy MCD-09, Privacy and Confidentiality, detail Healthy Blue's processes for implementing regulations in the operation and administration to ensure compliance with HIPAA and privacy regulations.

Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation indicates that the organization is capable of meeting SCDHHS' contract requirements. Security policies and procedures that align with industry best practices and adhere to the requirements were provided. Claims statistics show that Healthy Blue is capable of exceeding the requirements for processing claims. Specifically, Healthy Blue reported 98% of claims are processed within 14 days. Finally, Healthy Blue's Disaster Recovery Plan

and execution is commendable. The MCO's Disaster Recovery tests demonstrate that critical infrastructure and applications can be successfully recovered within the organization's recovery time objectives, and recovery point objectives.

Provider Services:

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

The Healthy Blue Credentialing Program Plan and related policies detail processes and requirements for initial and ongoing credentialing of practitioners and organizational providers. Review of the policies revealed lack of documentation related to appeals of credentialing denials, notification of internal departments and SCDHHS of credentialing denials, provider rights and processes for ensuring a non-discriminatory credentialing process, and processes for verifying the Medicaid ID number. All initial credentialing and recredentialing files were compliant with credentialing and recredentialing requirements.

The Credentialing Committee oversees the Credentialing Program and is ultimately responsible for credentialing decisions. The committee meets monthly, and the quorum is established with the presence of at least three voting members. Voting members include a variety of medical practitioners and several mid-level practitioners. Review of committee minutes revealed several voting members did not meet the attendance requirement.

Geographic access standards for primary care providers (PCPs), specialty providers, and hospitals are defined in policy. Healthy Blue evaluates the geographic adequacy of its network at least annually by conducting Geo Access mapping and analyzing results of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys, member complaints, and grievances. The February 2023 analysis demonstrated evaluation of time and distance access on a county-by-county basis for all required Status 1 providers except Rehabilitative Behavioral Health. Appointment access standards are well-documented in policy. Through a vendor, Healthy Blue conducts annual telephone surveys to evaluate provider compliance with appointment access standards. Results of the 2022 telephone survey, including identified issues and interventions to address the issues, were documented in the 2022 Quality Management Program Evaluation.

CCME also conducted a Telephonic Provider Access Study for a random sample of 161 PCPs drawn from a provider listing provided by Healthy Blue. The calls were successfully answered 69.3% of the time when omitting calls answered by voicemail messaging services. This is an improvement from last year's rate of 69%. The majority of calls considered to be unsuccessful were because the provider was not at the listed office or phone number. Of 108 providers contacted, 91% confirmed that they accept Healthy

Blue, and 58% of those accepting Healthy Blue take new patients. 74% were compliant with routine appointment availability.

Healthy Blue's Cultural and Linguistic Program is in place to ensure culturally competent and linguistically appropriate services for members with diverse cultures and beliefs; limited English proficiency; and impaired literacy, hearing, speech, and vision. The Provider Manual addresses culturally and linguistically competent care, and the website links to external resources for additional information.

Initial provider orientation and ongoing provider education are addressed in policy. Orientation is conducted at initial contracting and includes a variety of topics to enhance new provider understanding of the health plan's programs, processes, and requirements. Ongoing education is accomplished through virtual provider training sessions, written materials, mailings, annual workshops, etc. Additional resources for providers include the Provider Manual and health plan website. CCME noted that the Provider Manual covers member benefits but does not address BabyNet services or Rehabilitative Services for Children. The website's "Provider education" page provides printable information on a variety of topics and links to additional resources. Providers can also register for the Provider Pathways eLearning tool that offers additional educational resources.

On behalf of Healthy Blue, Amerigroup reviews and approves preventive health guidelines and clinical practice guidelines. Healthy Blue educates providers about the guidelines through initial orientation and ongoing education processes, and the guidelines are posted on the website.

Providers are educated about medical record documentation standards, and compliance is monitored through annual medical record compliance audits. The average score for the 2022 Medical Record Compliance Audit was 96.03 and all providers received a passing score. Results were reported to the Clinical Quality Improvement Committee in April 2023.

Member Services:

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

Healthy Blue emphasizes the commitment that all members are treated in a manner that acknowledges their rights and responsibilities listed in policy, the Healthy Blue Evidence of Coverage Manual (Member Handbook), Provider Manual, and on the website.

Members receive New Member Packets within 14 calendar days from the date of receipt of member's enrollment data. The New Member Packet – Contents policy outlines the information and instructions received by members during the enrollment process.

The Member Handbook includes a Quick Reference Guide that details the routine and specialty services and medical equipment requiring authorizations or copays. Information on obtaining prescription medications and durable medical equipment is outlined in the Member Handbook, and members are directed to the website to view the Preferred Drug List. Instructions for accessing 24-hour care are clearly outlined in the Member Handbook. Members are informed about the Nurse Advice Line as an additional resource. However, the PCP is emphasized as the first point of contact for assistance, with 911 to be used for life-threatening emergencies.

Steps for the selection of a PCP are outlined in the Member Handbook and on the website. Assistance is available via the Customer Call Center. Disenrollment information is described in the Member Handbook, the Provider Manual, the website, and in policy.

Healthy Blue contracts with Center for the Study of Services, a certified CAHPS survey vendor, to conduct child and adult satisfaction surveys. Results of the satisfaction surveys are presented to the Quality Improvement Committee (QIC) and network providers. The analysis and implementation of interventions to improve member satisfaction are discussed during the committee meetings.

Policies and procedures for the receipt of and response to member grievances in a manner consistent with contract requirements are outlined in policy GAXX 015, Grievance Process: Members-SC, the Member Handbook, and the Provider Manual. Members are informed that grievances may be filed verbally or in writing at any time by the member or an authorized representative. Healthy Blue acknowledges grievances within five calendar days and resolves grievances within 90 calendar days. A 14-day extension may be requested if needed. Staff are tasked with the responsibility of tracking, logging, and analyzing trends in grievances filed.

The 2023 EQR review of randomly selected grievance files found significant improvement made from the previous EQR, resulting in timely acknowledgement and resolution letters.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

The 2023 Medicaid Quality Management Program Description describes Healthy Blue's primary goal as improving the quality and safety of clinical care and services provided to members through Healthy Blue's network of providers and its programs and services. Healthy Blue's President/Chief Operating Officer is the senior executive responsible for the Quality Improvement (QI) Program. The Medical Director and Behavioral Health Medical Director provide clinical oversight.

The QI Program Description mentions (page 13) "Annually, the Plan makes information about the QI program's progress against goals available to the members." Healthy Blue's

website contained information regarding the QI Program. However, this information was outdated (2021).

Healthy Blue's QI Work Plan identifies specific activities and projects undertaken by the health plan. The 2022 and 2023 Work Plans, which document the planned activities, responsible parties, updates, and status for each activity, were submitted for review. The Clinical Quality Improvement Committee (CQIC) and the Service Quality Improvement Committee (SQIC) support the administration of Healthy Blue's QI activities. Membership includes internal and external health plan staff and external network providers. The internal staff include management from various areas. Voting members include seven actively participating network providers, who specialize in family medicine, OB/GYN, pediatrics, emergency medicine, and psychiatry.

Annually, Healthy Blue's QI department formally evaluates the program's overall effectiveness by analyzing outcomes from QI activities and data trends. The 2022 QI Program Evaluation was provided for review. This QI Program Evaluation included the results of the QI activities completed in 2022, a barrier analysis, any actions or interventions taken, and an assessment of the effectiveness of the interventions. The QI Program Evaluation was reviewed and approved by the CQIC in May 2023.

Performance Measure Validation: Healthy Blue produces HEDIS rates using software from an NCQA-certified measure vendor. The performance measure validation found that Healthy Blue was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b).*

All relevant HEDIS PMs for the current measure year (2021), the previous measure year (2020), and the change from 2020 to 2021 are reported in the QI section of this report. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial rate increases or decreases from 2020 to 2021. Rate changes shown in green indicate a substantial improvement (>10%) and rates shown in red indicate a substantial decline (>10%). Substantial changes in year-over-year trending were found in five measures.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	Change from 2020 to 2021
Substantial Increase in Rate (>10% improvement)			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Cholesterol Testing -Total	24.92%	38.22%	13.30%
Blood glucose and cholesterol testing - Total	23.40%	35.99%	12.59%

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	Change from 2020 to 2021
Substantial Decrease in Rate (>10% decrease)			
Childhood Immunization Status (cis)			
Influenza	45.99%	35.52%	-10.47%
Cardiovascular monitoring for people with cardiovascular disease and schizophrenia (smd)	60.00%	50.00%	-10.00%
Use of Imaging Studies for Low Back Pain (lbp)	70.77%	54.67%	-16.10%

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

For the 2023 review, two PIPs were submitted and validated. The non-clinical PIP was CAHPS Customer Service, and the clinical PIP was Comprehensive Diabetes Care. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions are included.

Table 2: CAHPS – Customer Service PIP

CAHPS - Customer Service	
The aim for this PIP is to improve the Child CAHPS measure: Customer Service Provided Information/Help. This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass. This PIP showed an improvement in the rate for the percentage of members rating customer service from 81.1% MY 2020 to 83.8% in MY 2021. The documentation showed interventions addressing the response rate and the language barriers as well as customer service-related interventions.	
Previous Validation Score	**Current Validation Score**
88/93= 95% High Confidence in Reported Results	99/99=100% High Confidence in Reported Results
Interventions	
• Oversampling • Provide a Spanish Survey	

Table 3: Comprehensive Diabetes Care PIP

Comprehensive Diabetes Care	
The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. The rate for poor control (HbA1C > or = 9) declined from 51.09% for baseline to 41.61% remeasurement one, which is improvement, as the goal is to lower the rate. The retinal eye exam rate increased from 35.52% at baseline to 35.77% at remeasurement one.	
Previous Validation Score	**Current Validation Score**
93/93= 100% High Confidence in Reported Results	99/99= 100% High Confidence in Reported Results
Interventions	
• Targeted text messages and outreach calls to members who have been diagnosed as diabetic to ensure the member has their HbA1c screenings and Diabetic Retinal Eye Exams. • Members who become compliant on the following services - A1c test, eye exam, and completion of diabetes survey - will be able to choose gift cards from various platforms. In addition to gift cards, members can receive fresh fruits and vegetables. • Practice Consultants visit (webinars) providers, review their current Gap in Care, provide a PowerPoint presentation with HEDIS information, and answer any questions that the provider may have. • Case Managers offer members assistance with PCP appointments, pharmacy, and any Social Determinants of Health needs.	

Utilization Management:

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

CCME's review of the Utilization Management (UM) Program entailed a review of the Utilization Management Program Description, Care Management Program Description, Pharmacy Program Description, various policies, approval files, denial files, appeal files, and care management files.

Healthy Blue's Utilization Management Program Description outlines the staff responsibilities, scope, and objectives for physical health and behavioral health services. The Pharmacy Program Description and various policies provide an overview and structure of the pharmacy program.

The Director of Healthcare Management is responsible for ensuring the integration of best care practices and quality delivery of UM and Care Management services. Heathy Blue's Medical Directors provide clinical oversight of UM decisions. The Director of Pharmacy Regulatory and Compliance provides supervision of the pharmacy program. The Behavioral Health Managing Medical Director provides oversight of the Behavioral Health UM Programs.

The UM Staff are qualified professionals that entail licensed clinicians that provide initial clinical reviews for authorization requests. Nonclinical staff provide support to the UM staff, and the Healthcare Management Team Leaders provide supervision to the UM staff and nonclinical staff. Also, Healthy Blue utilizes several methods to ensure quality assurance for clinical reviewers through Inter Rater Reliability (IRR) testing and monthly focused review audits.

Review of the approval and denial files reflected that the files appeared to be completed in a timely manner and were processed according to contractual standards.

The Complex Case Management Program Description and various policies provide a descriptive overview and processes for Healthy Blue's Case Management and Care Coordination Program.

Members are referred for case management services through various referral sources. Policy GBD_CM_102, Complex Case Management, referenced a policy that described additional information on the member referral process; however, the referenced policy is no longer active.

Healthy Blue has developed strategies to increase member engagement in the care management program and promote wellness. The Population Health Workgroup, which is comprised of clinical and nonclinical staff, meets monthly to develop strategies to increase member engagement and promote wellness. Additionally, within the Complex Care Management Program Description, a description of the Clinical Advisory Group noted a composition of clinical and nonclinical leadership that meets quarterly and provides oversight. However, during onsite discussion, the health plan identified that currently, there was not a Clinical Advisory Group.

A review of Healthy Blue's care management files indicated that care management activities are conducted appropriately according to contractual requirements.

Healthy Blue's appeals guidelines and procedures are outlined in the Utilization Management Program Description, Provider Manual, Member Handbook, and various policies. Standard appeals are processed within 30 days, and expedited appeals are processed within 72 hours. Policy SC_GAXX_051, Member Appeals Process, identified that if a standard appeal determination is not made within the established timeframes, the member's request would be approved. However, the policy does not address that expedited appeals will be considered approved if an appeal determination is not made within the established timeframes.

Appeal quarterly reports are presented to the SQIC and trends and opportunities for improvement are discussed. A yearly summary is also included in the UM Annual Evaluation and Quality Management Evaluation.

In the review of the appeal files, CCME found the files were processed timely; however, there were issues identified with the acknowledgement and extension letters for expedited appeal requests.

Delegation:

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

Processes that must be followed to delegate health plan activities to external entities are addressed in policies. Prior to approving delegation, the health plan conducts pre-delegation assessments to evaluate potential delegates' abilities to comply with contractual, health plan, federal, and/or accreditation requirements and standards. Upon approval of delegation, a written delegation agreement is implemented that specifies delegate activities and responsibilities, reporting requirements, actions that may result from non-compliant or sub-standard performance, etc. Each delegate is subjected to ongoing monitoring and a formal annual evaluation to assess compliance with the delegation agreement and applicable standards for the activities delegated.

Oversight documentation for Healthy Blue's delegates confirmed timely annual oversight with documentation of any identified issues and resulting corrective actions and recommendations as appropriate. Audit tools were thorough and included all requirements. Documentation of oversight is reported routinely through the Delegation Operations Committee (DOC), Credentialing Committee, and other applicable committees.

State Mandated Services:

42 CFR § Part 441, Subpart B

Policies describe processes for evaluating provider compliance with preventive care recommendations, including immunizations. Healthy Blue monitors providers' compliance with provision of recommended EPSDT services and immunizations for members primarily through the annual medical record audit. In addition, HEDIS gap-in-care data is monitored on a monthly basis.

Healthy Blue provides all core benefits specified by the *SCDHHS Contract*.

Quality Improvement Plans and Recommendations from Previous EQR

During the 2022 EQR, five standards were scored as "Partially Met" and one standard was scored as "Not Met." The following is a high-level summary of those deficiencies:

- Policy MCD-11, Medicaid Access/Availability Standard, included appointment standards for Health Maintenance and Preventative Care that are not monitored. Also, the policy does not address the requirement from the *SCDHHS Contract, Section 6.2.2.3.5*, that

"Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures."

- Policy SC_GAXX 015, Grievance and Appeals for Members, indicates that a written acknowledgement of the member's grievance is sent within five calendar days of receipt of the grievance. CCME reviewed a sample of grievance files and found that three of the files did not meet Healthy Blue's Policy SC_GAXX-015 for sending a written acknowledgement within five calendar days.
- The Preferred Drug List (PDL) change document found on the website included the effective date, the product name, and the changes made. It was not clear when the changes were posted to the website. Page 10 of the Pharmacy Program Description indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the *SCDHHS Contract* requires the change be published on the website at least 30 days prior to implementation.
- CCME's review of appeal files concluded that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process.
- For credentialing delegates, the file review worksheets do not provide evidence that the delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges.
- The 2022 EQR revealed that a deficiency identified during the 2021 EQR was not corrected.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found all Quality Improvement Plans had been implemented.

Conclusions

Overall, Healthy Blue met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 4: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Healthy Blue's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

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

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	8	7	88%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	38	97%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	19	95%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	11	11	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	14	14	100%

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

As noted in the table above:

- For Availability of Services and Assurances of Adequate Capacity and Services, Geo Access mapping did not include all required Status 1 provider types.
- For Provider Selection, policies did not clearly address all elements of the credentialing process related to appeals of credentialing denials, notifications of

credentialing denials, provider rights and processes for ensuring a non-discriminatory credentialing process, and verification of organizational providers' Medicaid ID.

- The appeal acknowledgement letters, and the appeal extension letters contained the incorrect timeframes for resolution.

Table 5: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2022 review. For 2023, 212 out of 215 standards received a score of "Met". There were three standards scored as "Partially Met," and no standards received a "Not Met" score.

Table 5: Scoring Overview

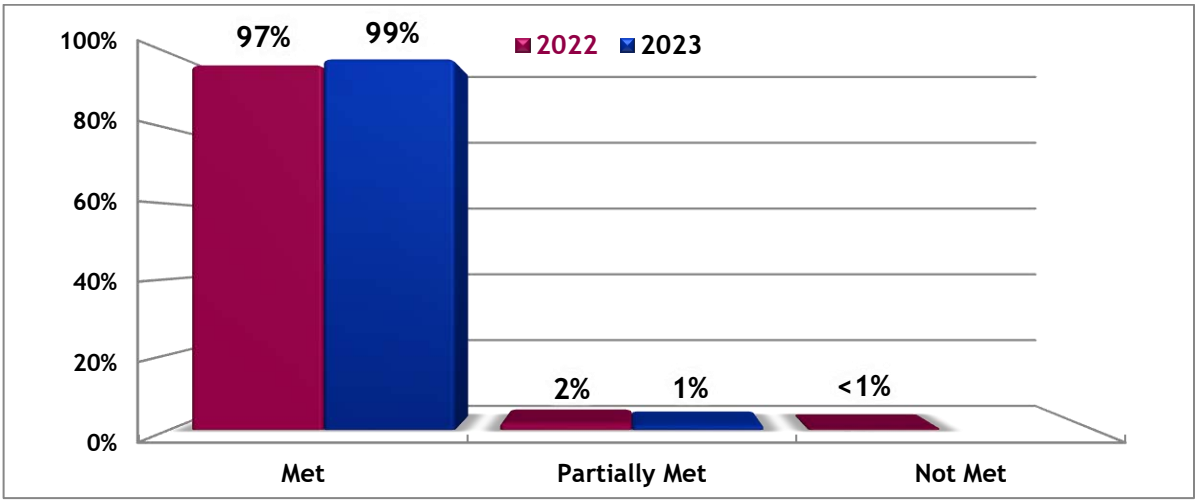
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	40	0	0	0	0	40	100%
2023	40	0	0	0	0	40	100%
Provider Services							
2022	75	1	0	0	0	76	99%
2023	74	2	0	0	0	76	97%
Member Services							
2022	32	1	0	0	0	33	97%
2023	33	0	0	0	0	33	100%
Quality Improvement							
2022	14	0	0	0	0	14	100%
2023	14	0	0	0	0	14	100%
Utilization							
2022	43	2	0	0	0	45	96%
2023	45	1	0	0	0	46	98%
Delegation							
2022	1	1	0	0	0	2	50%
2023	2	0	0	0	0	2	100%
State Mandated Services							
2022	3	0	1	0	0	4	75%
2023	4	0	0	0	0	4	100%
Totals							

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2022	208	5	1	0	0	214	97.20%
2023	212	3	0	0	0	215	98.60%

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

The 2023 Annual EQR shows that Healthy Blue achieved "Met" scores for 99% of the standards reviewed as the following chart indicates. This chart provides a comparison of the current review results to the 2022 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

The following is a summary of key findings and recommendations or opportunities for improvements. Specific details of Strengths, Weaknesses, and Recommendations can be found in the sections that follow.

Table 6: Evaluation of Quality

Strengths Related to Quality
• Healthy Blue's commitment to providing staff with hands on knowledge and decision-making capabilities regarding program integrity to coordinate Fraud, Waste, and Abuse efforts with the Program Integrity/SUR Division is detailed in the Compliance Plan. • Healthy Blue's Performance Improvement and Enhancement Team conducts monthly random case sample audits to ensure consistency in clinical application and timeliness of authorization processing of clinical reviewers. • Voting members of the Credentialing Committee include a variety of medical practitioners and mid-level practitioners.

Strengths Related to Quality
• Initial credentialing and recredentialing files for practitioners and organizational providers were compliant with all credentialing requirements. • Provider educational materials are comprehensive, and the Provider Manual and health plan website include a wealth of resources for providers to operate effectively within Healthy Blue's network. • The Performance Measures were compliant with the HEDIS technical specifications for rate calculations. • All Performance Improvement Projects received validation scores within the High Confidence range. • Healthy Blue's Community Health Workers Outreach team was expanded since the last EQR to include a social worker to assist members at a clinical level. • Policies and procedures detail requirements for pre-delegation assessments, implementation of delegation agreements, and ongoing monitoring and evaluation of delegates. • Written delegation agreements implemented with each delegated entity specify the delegated activities, delegate responsibilities, reporting requirements, consequences of non-compliance or sub-standard performance, etc. • Documentation of delegate oversight confirmed annual audits are conducted and audit tools address all requirements for the delegated functions. • Provider compliance with provision of recommended immunizations and EPSDT services is monitored through the annual medical record review audit and by monitoring HEDIS data. • All core benefits are provided to members. • All deficiencies from the previous EQR were addressed.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Onsite discussion confirmed practitioners may appeal credentialing denials when the denial is not related to loss of licensure, sanctions, or exclusions. However, Policy MCD-04, Initial Credentialing, states only that providers may appeal when "there is an absence of explanatory documentation or the provider has responded affirmatively to the Health and History section questions of the application."	• Quality Improvement Plan: Revise Policy MCD-04 to include detailed information about the circumstances under which a provider may appeal a denial of credentialing.
• Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing, does not address provider appeal rights related to credentialing and recredentialing; processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing; provider rights and processes for ensuring a non-discriminatory credentialing process; and processes for verifying that organizational providers have a current Medicaid ID number.	• Quality Improvement Plan: Revise Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing, to address provider appeal rights related to credentialing and recredentialing; processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing; provider rights and processes for ensuring a non-discriminatory credentialing process; and processes for verifying that organizational providers have a current Medicaid ID number.
• Review of Credentialing Committee minutes from February 2022 through February 2023 revealed that three voting members did not meet the attendance requirement of 60% of meetings.	• Recommendation: Reinforce attendance expectations for members of the Credentialing Committee. Consider recruiting an additional OBGYN provider for membership on the committee.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• During review of the online Find a Doctor tool, non-functional links for FAQs and Conditions of Use were noted.	• Recommendation: Correct the nonfunctional links to the FAQs and Conditions of Use on the Find a Doctor page of Healthy Blue's website.
• CarelonRx changed their name from IngenioRx in January 2023. Even though the name has recently changed from IngenioRx to CarelonRx, the Pharmacy Program Description continues to reflect IngenioRx as the pharmacy benefit manager.	• Recommendation: Update all documentation and communication to reflect the Pharmacy Benefit Manager's name change to CarelonRx.
• Policy SC_GAXX_051, Member Appeals Process, does not address that expedited appeals will be considered approved if an appeal determination is not made within the established timeframes.	• Recommendation: Consider adding in Policy SC_ GAXX_051, Member Appeal Process, that an expedited appeal determination will be deemed approved if a determination is not made within the established timeframes.
• Issues identified in the appeal file review included acknowledgement letters and appeal extension letters that communicated incorrect timeframes for resolution.	• Quality Improvement Plan: Ensure the acknowledgement letters and appeal extension letters communicate the correct timeline for resolution.
• The Complex Care Management Program Description provided an overview of a Clinical Advisory Group that provides oversight of the care management program. However, during onsite discussion, the health plan identified that there was not currently a Clinical Advisory Group.	• Recommendation: Remove reference to Clinical Advisory Group within the Complex Care Management Program Description as this is identified as not providing oversight of the care management program.
• Healthy Blue's website contained information regarding the QI Program, however; this information was outdated (2021).	• Recommendation: Update the QI information on the Healthy Blue's website.

Table 7: Evaluation of Timeliness

Strengths Related to Timeliness
• Healthy Blue's policies and procedures are reviewed annually with revisions made available to staff.
• Claims processing capabilities exceed *SCDHHS Contract* requirements.
• Denial files were completed timely and provided a clear explanation for the reasoning for the adverse benefit decision.
• Healthy Blue demonstrated significant improvement from the previous review regarding the timely acknowledgement and resolution of member grievances.

Table 8: Evaluation of Access to Care

Strengths Related to Access to Care
• Policies appropriately document geographic access standards for various provider types and network analyses indicate 100% of members have the required access to PCPs.

Strengths Related to Access to Care
• Processes are in place to ensure Healthy Blue's network can meet the cultural and linguistic needs of its membership, and the MCO conducts provider education regarding cultural competency. The Provider Manual and website include comprehensive information and resources for providers related to Cultural Competency. • Processes are established to ensure Provider Directories include all required information and are updated with new or revised provider information in a timely manner. • The successful contact rate for the provider access call study conducted by CCME improved from the previous year. • Documented appointment access standards are compliant with contractual requirements, and policies describe the process for assessing provider compliance with the appointment access standards. For 2022, barriers were identified, and interventions were implemented to address the barriers. • Healthy Blue's Population Health Work Group is designed to identify barriers for member engagement in the care management program and develop strategies to increase member wellness and engagement. • Healthy Blue has developed networking relationships with community partners and provides incentives to members to increase member engagement in the care management program.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• The Healthy Blue Network Analyses for Driving Time and Driving Distance did not include measurement of time and distance for Rehabilitative Behavioral Health providers, who are classified as Status 1 providers by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*	• Quality Improvement Plan: Ensure Geo Access mapping includes all required Status 1 provider types. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*
• The Provider Manual addresses member benefits but does not address BabyNet services or Rehabilitative Services for Children.	• Recommendation: Revise the Provider Manual to include information about BabyNet services and Rehabilitative Services for Children.
• Policy GBD_CM_102, Complex Case Management, referenced Policy GBD CM 101, Member Identification and Assessment of Populations, as policy reference to provide additional information on the member referral process. However, during onsite discussion, Healthy Blue reported that this policy is no longer active.	• Recommendation: Remove the reference to Policy GBD_CM_101, Member Identification and Assessment of Populations, from Policy GBD_CM_102, Complex Case Management (Care Compass), as this policy is no longer active.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the EQR of a Medicaid MCO/PIHP and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On March 13, 2023, CCME sent notification to Healthy Blue 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 Healthy Blue to ask questions regarding the EQR process and the requested desk materials.

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

The second segment was a virtual onsite review originally scheduled for May 17, 2023, and May 18, 2023. Due to a change in CCME's EQR contract, the onsite was conducted on June 21st and 22nd. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Healthy Blue's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between Healthy Blue and SCDHHS. Strengths, Weaknesses, and Recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 4*).

A. Administration

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

The Administration section of the EQR focuses on policies, procedures, and documents for standards covering staffing, information systems, compliance, program integrity, and confidentiality.

Healthy Blue's policies and procedures are reviewed by the Compliance Committee on an annual basis, per Policy MCD-16, Policy Development, Review, and Management. Each business unit develops and maintains policies ensuring compliance with appropriate state and federal laws, regulations, and other regulatory entities. Employees have access to all policies in a shared network drive. A bimonthly newsletter is provided to all Healthy Blue employees that contains a grid highlighting any policy revisions.

The review of Healthy Blue's 2022/2023 Organizational Chart and Key Personnel List found that all contractually required positions are identified. Tim Vaughn serves as Healthy Blue's President and Chief Operating Officer. Amy Bennett is listed as Healthy Blue's Contract Account Manager and Interagency Liaison. Dr. Imtiaz Khan serves as the Medical Director and Dr. Jorge Hernandez-Chaple is the Behavioral Health Medical Director.

The Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan provides details regarding the establishment and maintenance of ethical standards for business operations. Standards of ethical practices are detailed in the Our Values Code of Conduct document.

Healthy Blue has established a Compliance Committee to oversee the development and implementation of the Compliance Plan and provide ongoing monitoring, review, and assessment of the effectiveness of the Compliance Plan. The Compliance Committee meets quarterly at a minimum and more frequently as needed.

All employees complete the Compliance Challenge course at hire and annually thereafter. This training covers ethics and the code of conduct; HIPAA privacy and security; and fraud, waste, and abuse (including The False Claims Act and other relevant legislation). Lines of communication are available to report fraud, waste, abuse, criminal activity, conflicts of interest, and breaches of ethical business conduct standards. Healthy Blue's Compliance Plan outlines their enforcement standards and approach to resolve any compliance issues. Appropriate disciplinary actions are taken for any violation of the Compliance Plan.

Healthy Blue monitors members' use of prescription drugs for potential over-utilization of prescribers, medications, and pharmacies through the Pharmacy Lock-In Program. The monitoring process is outlined in Policy RX LOCK 43150, Lock-In SC Medicaid. Guidelines are specific to restrictions related to the pharmacy program to reduce costs and improve quality of life through enhanced coordination of care.

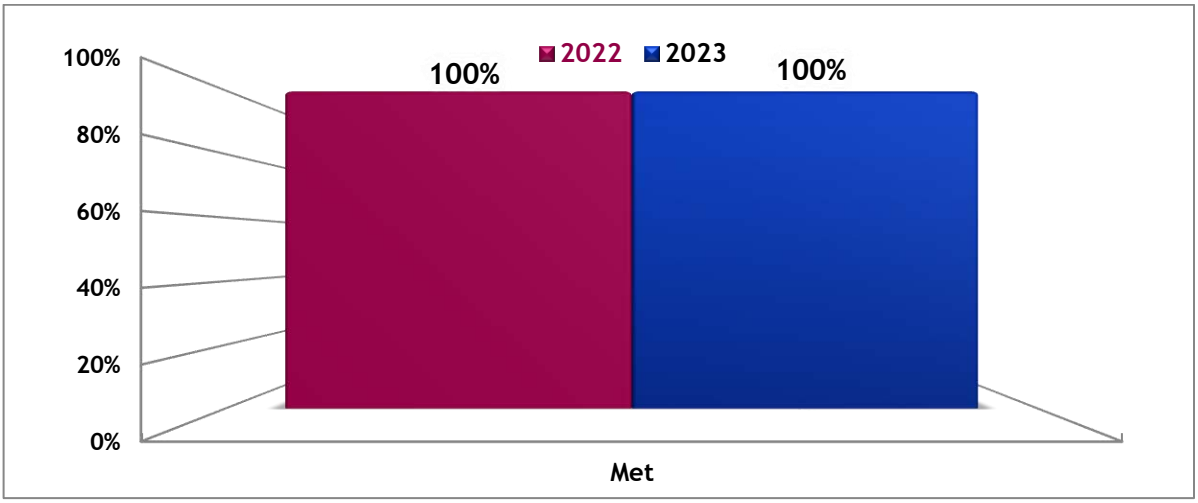
The Compliance Plan and Policy MCD-09, Privacy and Confidentiality, detail Healthy Blue's processes for implementing regulations in the operation and administration to ensure compliance with Health Insurance Portability and Accountability Act (HIPAA).

Information Management Systems Assessment

Healthy Blue's Information Systems Capabilities Assessment (ISCA) documentation indicates that the organization is capable of meeting SCDHHS's contract requirements. Security policies and procedures that align with industry best practices and adhere to the requirements were provided. Claims statistics show that Healthy Blue is capable of exceeding the requirements for processing claims. Specifically, Healthy Blue reported 98% of claims are processed within 14 days. Finally, Healthy Blue's Disaster Recovery Plan and execution is commendable. The MCO's Disaster Recovery tests demonstrate that critical infrastructure and applications can be successfully recovered within the organization's recovery time objectives and recovery point objectives.

In the Administration section of the review, Healthy Blue received "Met" scores for 100% of the standards reviewed, as illustrated in *Figure 2: Administration Findings*.

Figure 2: Administration Findings



Strengths

- Healthy Blue's policies and procedures are reviewed annually with revisions made available to staff.
- Claims processing capabilities exceed contractual requirements.
- Healthy Blue's commitment to providing staff with hands on knowledge and decision-making capabilities regarding program integrity to coordinate FWA efforts with Program Integrity/SUR Division is detailed in the Compliance Plan.

B. Provider Services

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

The review of Provider Services includes credentialing and recredentialing, provider network adequacy and practitioner accessibility, provider education processes, provider compliance with preventive health guidelines (PHGs) and clinical practice guidelines (CPGs), continuity of care, and practitioner medical record requirements.

Provider Credentialing and Selection

Credentialing processes and requirements are documented in the Healthy Blue Credentialing Program Plan and various policies, including Policy MCD-04, Initial Credentialing, Policy MCD-05, Recredentialing, and Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing. Delegation of credentialing activities is addressed in Policy MCD-10, Credentialing Delegation. Review of these documents revealed that Policy MCD-04 includes incomplete information about the circumstances under which a practitioner can appeal a denial of credentialing. In addition, Policy MCD-06 does not address:

- Provider appeal rights related to credentialing and recredentialing.
- Processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and South Carolina Department of Health and Human Services (SCDHHS) of a denial of credentialing.
- Provider rights and processes for ensuring a non-discriminatory credentialing process.
- Processes for verifying that organizational providers have a current Medicaid ID number.

Healthy Blue's Credentialing Committee oversees the Credentialing Program. Ultimate responsibility for making credentialing and recredentialing decisions rests with this committee. However, approval of "clean" credentialing files is delegated to the Medical Director. The Credentialing Committee meets monthly, and the presence of at least three voting committee members constitutes a quorum. Voting members include a variety of medical practitioners and several mid-level practitioners. The committee is chaired by the Associate Medical Director, who votes only to break a tie. Review of Credentialing Committee minutes from February 2022 through February 2023 confirmed that three voting members did not meet the attendance requirement of 60% of meetings.

The review of a sample of initial credentialing and recredentialing files for practitioners and organizational providers revealed all were compliant with credentialing and recredentialing requirements.

The Credentialing Committee or Medical Director may restrict, suspend, or terminate network providers when issues related to quality of care or service are identified, when sanctions are identified, and when the provider does not meet credentialing standards. Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination, describes processes for monitoring for provider sanctions and exclusions; restricting, suspending, and terminating providers; notifying providers of actions taken and appeal rights; and reporting to SCDHHS, the NPDB, the state licensing board, and other appropriate entities.

Availability of Services

Geographic access standards for primary care providers (PCPs), specialty providers, and hospitals are defined in Policy MCD-11, Medicaid Access and Availability. The standards are compliant with contractual requirements. Healthy Blue evaluates the geographic adequacy of its network at least annually by conducting Geo Access mapping and analyzing results of CAHPS Surveys, member complaints, and grievances. Onsite discussion confirmed network reports are submitted to SCDHHS at least twice each year. The Healthy Blue Network Analyses dated February 22, 2023 demonstrated evaluation of time and distance access on a county-by-county basis for all required Status 1 providers except Rehabilitative Behavioral Health providers.

Policy MCD-11, Medicaid Access and Availability, defines the appointment access standards with which network practitioners are expected to comply. The 2023 EQR confirmed Healthy Blue addressed a deficiency identified during the 2022 EQR related to incomplete documentation of appointment access standards in policy, the Provider Manual, and the Member Handbook. *Table 9: Previous Practitioner Accessibility QIP Items* lists the previously identified issue and Healthy Blue's response.

Table 9: Previous Practitioner Accessibility QIP Items

Standard	EQR Comments
Adequacy of the Provider Network	
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Requirements for specialty care appointments are found in the SCDHHS Contract, Section 6.2.3.1.5. For specialty providers, Policy MHSC-PS-005 does not include the requirements for emergent visits immediately upon referral and urgent medical condition care appointments within 48 hours of referral or notification of the PCP. The Provider Manual, pages 68-69, and the Member Handbook, page 29, include requirements for emergent visits and urgent medical condition care appointments; however, the information is found in table with a heading of "PCPs," so it is not clear that the information applies to specialist appointments. Also, the Provider

Standard	EQR Comments
	Manual and Member Handbook define the requirement for routine specialist appointments as 12 weeks; however, this is incomplete. *Quality Improvement Plan: Revise Policy MHSC-PS-005, the Provider Manual, and the Member Handbook to clearly state the requirements for specialty appointments. Ensure the information is compliant with the standards defined in the SCDHHS Contract, Section 6.2.3.1.5.*
Healthy Blue's Response: The Healthy Blue Compliance Committee approval to revise Policy MCD-11 Access and Availability Standards is complete as of June 20, 2022. The appointment standard for Health Maintenance and Preventative Care is removed and the information regarding "walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment" is added. The Provider Manual, page 119, reference regarding the appointment standard for Health Maintenance and Preventative Care is removed. See attachments: • QIP 1a_MCD-11 (June 2022) Access and Availability Standards • QIP 1b_Provider Manual 2023 DRAFT Page 119 Redline	

Healthy Blue contracts with Symphony Performance Health (SPH) Analytics, an NCQA certified survey vendor, to conduct annual telephone surveys to evaluate provider compliance with appointment access standards. The surveys focus on PCPs, high volume specialists (OBGYNs), and high impact specialists (Oncologists). Analysis of the results is conducted by Quality Improvement staff, Provider Services staff, and the Service Quality Improvement Committee (SQIC).

The 2022 Quality Management Program Evaluation includes the results of the 2022 survey and compares the results to the studies conducted in 2021 and 2020. The program evaluation included barriers, such as lack of provider awareness of appointment access standards, lack of provider awareness of member expectations for what is considered to be timely for specialty appointments, lack of member awareness of alternate options for urgent care, and decreased staffing/increased workloads due to the Covid-19 pandemic. Interventions to address the barriers were also included.

The Cultural and Linguistic Program was established to ensure culturally competent and linguistically appropriate services for members with diverse cultures and beliefs, limited English proficiency, and limitations or impairments of literacy, hearing, speech, and vision. Comprehensive information about the program is included in the Culturally and Linguistically Appropriate Services Policy. Healthy Blue's 2023 Provider Manual includes information about cultural competency, and the health plan's website links the user to the "My Diverse Patients" website, which includes learning modules, resources, and tools to further provider understanding of cultural competency.

As noted in the 2022 Quality Management Program Evaluation, Healthy Blue's 2022 evaluation of network adequacy included provider availability and accessibility data and member experience data. Out-of-network utilization requests and data were also considered. Opportunities for improvement were identified, and interventions were implemented to address the opportunities. These interventions focused on provider and member education; updating member materials to highlight using the website, telehealth services, and urgent care centers; and aiding members with locating participating providers. The Network Growth Report for MY 2022 indicates an increase of 279 providers.

Provider Access and Availability Study

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

For the Telephonic Provider Access Study conducted by CCME, Healthy Blue submitted a Provider File containing a population of 2,281 providers. A random sample of 161 PCPs was selected and attempts were made to contact these providers to ask a series of questions regarding the access that members have with the providers.

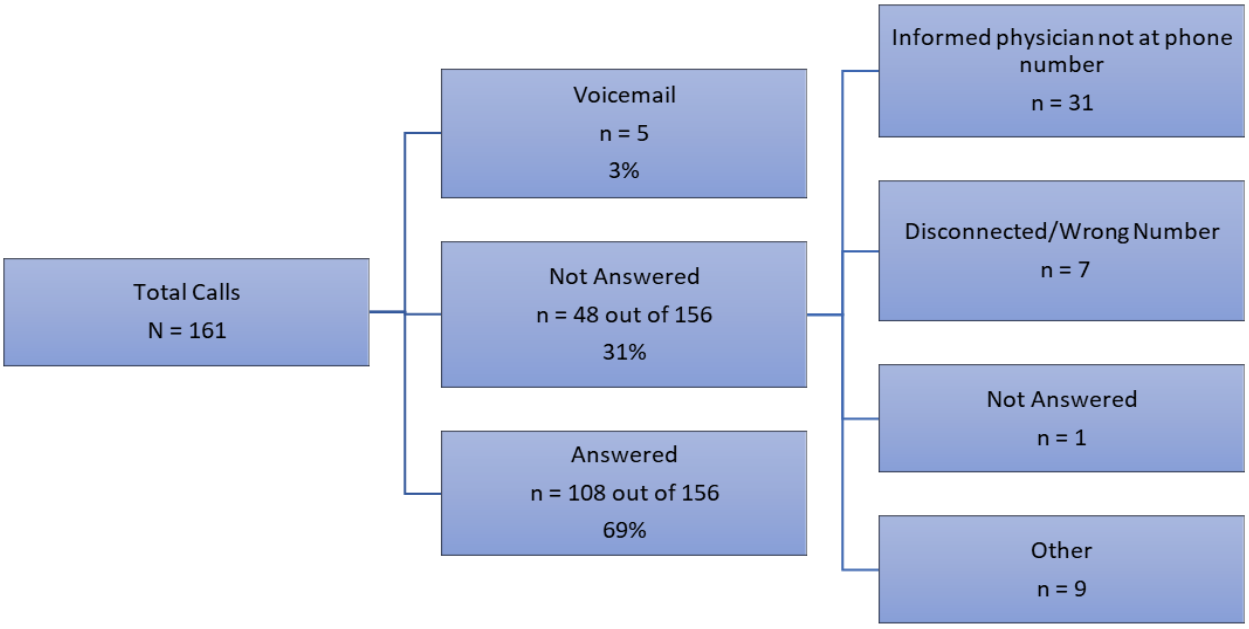
The calls were successfully answered 69.3% of the time (108 out of 156) when omitting five calls answered by voicemail messaging services. This is an improvement from last year's rate of 69%. See *Table 10: Telephonic Access Study Answer Rate Comparison*.

Table 10: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2022 Review	170	69.0%	.997
2023 Review	161	69.3%	

For the 48 calls not answered successfully, the majority (n = 31, 64.5%) were because the provider was not at the office or phone number listed. Out of 108 providers contacted, 98 (91%) confirmed that they accept Healthy Blue, and 57 (58%) of the 98 that accept Healthy Blue are also accepting new patients. For appointment availability, 42 of 57 (74%) met contractual requirements for routine appointment availability for a routine appointment, and 15 of 57 (26%) did not have an appointment within contract requirements. *Figure 3: Telephonic Provider Access Study Results* provide an overview of the findings of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for provider orientation and ongoing provider education are found in Policy MCD-01, Education of Contracting Providers. Orientation is conducted by Provider Network Management and/or Provider Education staff via in-person or virtual sessions at initial contracting. The orientation includes information about Healthy Blue and its programs, policies, procedures, Medicaid regulations, etc. New providers receive copies of a comprehensive PowerPoint presentation used for provider orientation. This presentation includes contact information for Provider Relations Representatives and other Healthy Blue departments and information about provider roles and responsibilities, self-servicing functions of the provider website, member transportation, benefits information, the prior authorization look-up tool, claims, etc.

Ongoing provider education is accomplished through virtual provider training sessions, provision of written materials and reference information, mailings, annual workshops, and routine provider contacts. Four regional provider trainings are provided annually and may be held virtually when on-site training is not an option.

Additional provider resources include the Provider Manual and health plan website. The Provider Manual is comprehensive and includes information necessary for new and established providers to understand and navigate health plan operations and requirements. The Provider Manual covers member benefits but does not address BabyNet services or Rehabilitative Services for Children. Healthy Blue's website has a "Provider

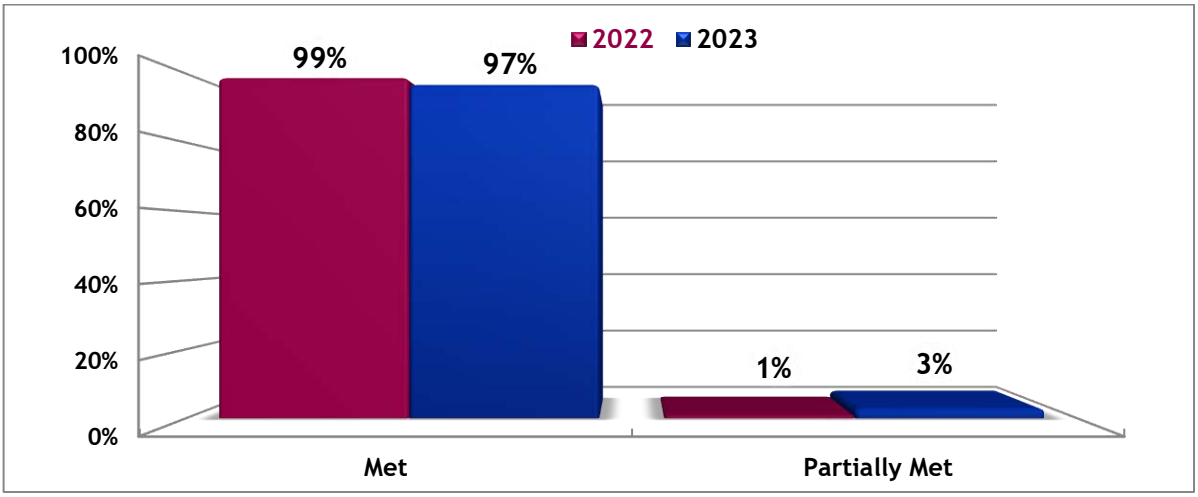
education" page which includes printable information about pertinent topics and provides links to the "My Diverse Patients" training website and to the "CMS Toolkit - Telehealth for Providers: What You Need to Know" website. Providers may also register for the Provider Pathways eLearning tool that offers additional educational resources.

Amerigroup reviews and approves PHGs and CPGs on behalf of Healthy Blue. The guidelines are evidence-based and adopted from nationally recognized sources to educate providers about recommended preventive care services and to aid in decision-making about acute and chronic medical and behavioral health conditions. Once the guidelines are reviewed and approved by Amerigroup, they are submitted to the health plan's Clinical Quality Improvement Committee (CQIC) for approval and adoption by the health plan. Healthy Blue educates providers about the PHGs and CPGs through provider orientation and ongoing education processes. The guidelines are posted on Healthy Blue's website and information about the guidelines and how to view/obtain the guidelines is included in the Provider Manual.

Providers are educated about medical record documentation standards via the Provider Manual and website, and Amerigroup conducts annual medical record compliance audits to evaluate provider compliance with the standards, as noted in Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards – SC. The 2022 Medical Record Compliance Audit was conducted on a sample of 109 records for 30 providers. The average score was 96.03 and no providers received a failing score. Results were reported to the CQIC in April 2023.

As noted in *Figure 4: Provider Services Findings*, 97% of the Provider Services standards were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 11: Provider Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Partially Met
	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- Voting members of the Credentialing Committee include a variety of medical practitioners and mid-level practitioners.
- Initial credentialing and recredentialing files for practitioners and organizational providers were compliant with all credentialing requirements.
- Policies appropriately document geographic access standards for various provider types and network analyses indicate 100% of members have the required access to PCPs.
- Processes are in place to ensure Healthy Blue's network can meet the cultural and linguistic needs of its membership, and the MCO conducts provider education regarding cultural competency. The Provider Manual and website include comprehensive information and resources for providers related to Cultural Competency.
- Processes are established to ensure Provider Directories include all required information and are updated with new or revised provider information in a timely manner.
- The successful contact rate for the provider access call study conducted by CCME improved from the previous year.
- Documented appointment access standards are compliant with contractual requirements, and policies describe the process for assessing provider compliance with

the standards. For 2022, barriers were identified, and interventions were implemented to address the barriers.

- Provider educational materials are comprehensive, and the Provider Manual and health plan website include a wealth of resources for providers to operate effectively within Healthy Blue's network.

Weaknesses

- Onsite discussion confirmed practitioners may appeal credentialing denials when the denial is not related to loss of licensure, sanctions, or exclusions. However, Policy MCD-04, Initial Credentialing, states only that providers may appeal when "there is an absence of explanatory documentation, or the provider has responded affirmatively to the Health and History section questions of the application."
- Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing, does not address:
  - Provider appeal rights related to credentialing and recredentialing.
  - Processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing. (This process is described in Policy MCD-04 and MCD-05 for practitioners.)
  - Provider rights and processes for ensuring a non-discriminatory credentialing process.
  - Processes for verifying that organizational providers have a current Medicaid ID number.
- Review of Credentialing Committee minutes from February 2022 through February 2023 revealed that three voting members did not meet the attendance requirement of 60% of meetings.
- The Healthy Blue Network Analyses for Driving Time and Driving Distance did not include measurement of time and distance for Rehabilitative Behavioral Health providers, who are classified as Status 1 providers by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2*.
- During review of the online Find a Doctor tool, non-functional links for FAQs and Conditions of Use were noted.
- The Provider Manual addresses member benefits but does not address BabyNet services or Rehabilitative Services for Children.

Quality Improvement Plans

- Revise Policy MCD-04 to include detailed information about the circumstances under which a provider may appeal a denial of credentialing.

- Revise Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing, to address provider appeal rights related to credentialing and recredentialing; processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing; provider rights and processes for ensuring a non-discriminatory credentialing process; and processes for verifying that organizational providers have a current Medicaid ID number.
- Ensure Geo Access mapping includes all required Status 1 provider types. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*

Recommendations

- Reinforce attendance expectations for members of the Credentialing Committee. Consider recruiting an additional OBGYN provider for membership on the committee.
- Correct the nonfunctional links to the FAQs and Conditions of Use on the Find a Doctor page of Healthy Blue's website.
- Revise the Provider Manual to include information about BabyNet services and Rehabilitative Services for Children.

C. Member Services

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

The member services section addresses member rights and responsibilities, member education, the Call Center, enrollment and disenrollment, member satisfaction, and grievances.

New member packets are mailed to members within 14 calendar days from the date Healthy Blue receives the member's enrollment data. Member rights and responsibilities are communicated to members and to participating providers through the Healthy Blue Evidence of Coverage (Member Handbook), the Provider Manual, and Healthy Blue's website. The Member Handbook includes a Quick Reference Guide that details the routine and specialty services and medical equipment requiring authorizations or copays. Information on obtaining prescription medications and durable medical equipment is outlined in the Member Handbook and members are directed to the website to view the Preferred Drug List. Instructions for accessing 24-hour care are clearly outlined in the Member Handbook. Members are informed about the Nurse Advice Line as an additional resource. However, the PCP is emphasized as the first point of contact for assistance, with 911 to be used for life-threatening emergencies.

During the onsite discussion, Healthy Blue shared that they have expanded the Community Health Worker Outreach team to include a social worker to provide clinical support to members specific to chronic health and disease management.

Steps for member enrollment and the selection of a PCP are outlined in the Member Handbook and on the website. Assistance is available via the Customer Call Center. Disenrollment information is described in the Member Handbook, the website, and in Policy SC_UMXX_125, Termination of Membership (Disenrollment) - Coordination of Care.

Member Satisfaction Survey

Healthy Blue contracts with Center for the Study of Services, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendor, to conduct the child and adult satisfaction surveys.

The child surveys met the minimum sample size of 411 valid surveys with a total of 454 completed out of 3,185. The response rate was 14.3%, which is a decline from the previous year's rate of 17.07%. Improvement was demonstrated for Getting Care Quickly, Rating of Health Plan, and Rating of all Health Care. The largest decline was noted in the Rating of Specialist Seen Most Often.

The Children with Chronic Conditions (CCC) survey sample was below the target of 411 with 328 completed surveys out of 2,673 for a response rate of 12.32%. This was a decline from the previous rate of 22.24%. The results showed improvement for Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care, Rating of Specialist Seen Most Often, Access to Prescription Meds, Access to Specialized Services, and Coordination of Care for CCC. The largest decline was notes as the Rating of Personal Doctor.

The Adult response rate was 10.5% (with 188 completed surveys out of the initial sample of 1,809), which is a decline from the previous year of 11.99%. Measures for Rating of All Health Care, Rating of Health Plan, and Customer Service improved. The largest decline occurred for Rating of Specialist Seen most often.

The results are presented to the Quality Improvement Committee and network providers. The analysis and implementation of interventions to improve member satisfaction are discussed during the committee meetings.

Grievances

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

Policies and procedures for the receipt of and response to member grievances are outlined in Policy GAXX 015, Grievance Process: Members-SC, the Member Handbook, and

in the Provider Manual. Members are informed that grievances may be filed verbally or in writing at any time by the member or an authorized representative. Healthy Blue acknowledges grievances within five calendar days and resolves standard grievances within 90 calendar days. A 14-day extension may be requested if needed. Staff are tasked with the responsibility of tracking, logging, and analyzing trends in grievances filed.

The review of randomly selected grievance files found significant improvement made from the previous EQR, resulting in timely acknowledgement and resolution letters.

Table 12: Previous Grievances QIP Items

Standard	EQR Comments
III F. Grievances	
2. The MCO applies grievance policies and procedures as formulated.	Policy SC_GAXX 015, Grievance and Appeals for Members, indicates that a written acknowledgement of the member's grievance is sent within five calendar days of receipt of the grievance. CCME reviewed a sample of grievance files and found that three of the files did not meet Healthy Blue's Policy SC_GAXX-015 for sending a written acknowledgement within five calendar days. *Quality Improvement Plan: Conduct an internal audit of files to ascertain compliance with Healthy Blue's grievance policy. Address any deficiencies with staff to determine interventions needed to improve performance.*
Healthy Blue Response: Per an internal audit of Grievance files and Policy SC_GAXX_015, the Healthy Blue Grievance and Appeals Department has implemented a process to address any deficiencies with staff and put in place interventions needed to improve performance. This new process consists of the following: • The grievance supervisor reviews report three days per week (Monday/Wednesday/Friday) of the current grievance cases (referred to as the work basket) and assignment of cases by aged date to specific team members. • The assigned team members are responsible for validating the electronic record for each grievance and verifying that an acknowledgement letter is generated timely, within five calendar days. All files not meeting timeliness standards are reviewed monthly for opportunities to further improve the workflow. Additionally, Healthy Blue Compliance is performing a quarterly audit process in which random grievance files are selected and reviewed for compliance with contract and regulatory standards. Any identified concerns are discussed with business owners to identify appropriate next steps	

The 2023 EQR found that 100% of the Member Services standards were scored as "Met."

Figure 5: Member Services Findings

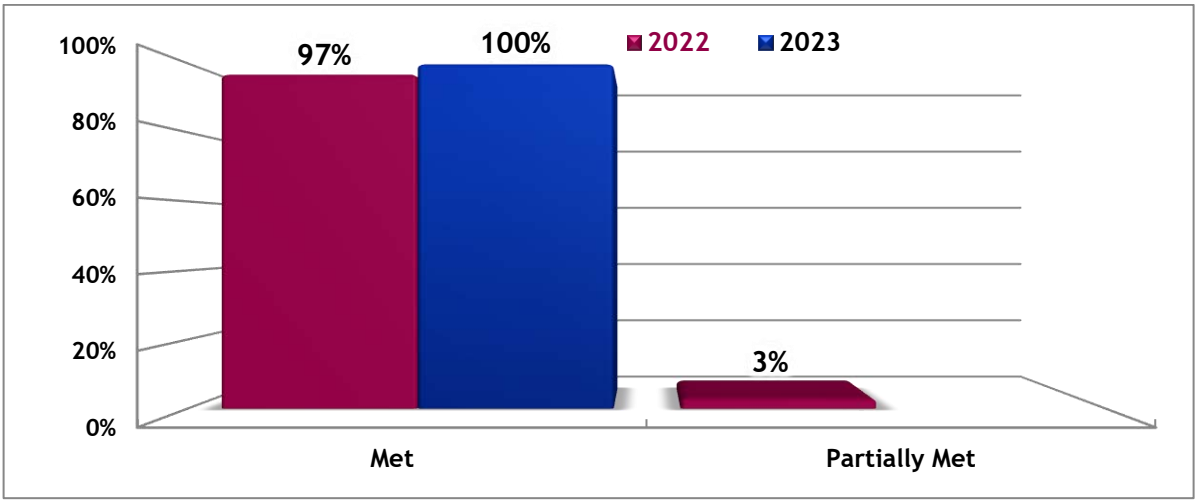


Table 13: Member Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Grievances	The MCO applies grievance policies and procedures as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- Healthy Blue demonstrated significant improvement from the previous review regarding the timely acknowledgement and resolution of member grievances.
- Healthy Blue's Community Health Workers Outreach team expanded since the last EQR to include a social worker to assist members at a clinical level.

D. Quality Improvement

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

Healthy Blue's 2023 Medicaid Quality Management Program Description describes Healthy Blue's primary goal as to improve the quality and safety of clinical care and services provided to members through Healthy Blue's network of providers and through its programs and services. Healthy Blue's President/Chief Operating Officer is the senior executive responsible for the Quality Improvement (QI) Program. The Medical Director and Behavioral Health Medical Director provide clinical oversight.

The QI Program Description mentions (page 13) "Annually, the Plan makes information about the QI program's progress against goals available to the members." Healthy Blue's website contained information regarding the QI Program; however, this information was from 2021 and therefore, outdated.

Over and underutilization of services data are monitored to help implement strategies to achieve utilization targets consistent with clinical and quality indicators. Utilization of services data are also used to identify potential fraud and abuse of services. Policy SC_UMXX_061, Under-and Over-Utilization of Services - Monitoring – SC, provides the process Healthy Blue follows for monitoring over and underutilization data.

Healthy Blue's QI Work Plan identifies specific activities and projects undertaken by the health plan. The 2022 and 2023 Work Plans were submitted for review. The work plans documented the planned activities, responsible parties, updates, and status for each activity.

The CQIC and the SQIC support the administration of Healthy Blue's QI activities. Membership includes internal and external health plan staff and external network providers. The internal staff include management from various areas. Voting members include seven actively participating network providers who specialize in family medicine, OB/GYN, pediatrics, emergency medicine, and psychiatry.

The CQIC is authorized to meet as necessary but no less often than quarterly. A meeting quorum is met with the attendance of three network providers. The committee chair votes only in the case of a tie vote by the network providers.

Minutes were provided for the CQIC meetings held in 2022 and the January and April 2023 meetings. It was noted that a quorum was not present for the meetings held on July 20, 2022 and April 16, 2023. Instead, documents requiring approval were sent to the voting members electronically for review and approval.

Annually, Healthy Blue's QI department formally evaluated the program's overall effectiveness by analyzing outcomes from QI activities and data trends. The 2022 Quality Management Program Evaluation was provided for review. This QI Program Evaluation included the results of the QI activities completed in 2022, a barrier analysis, any actions or interventions taken, and an assessment of the effectiveness of the interventions. The Program Evaluation was reviewed and approved by the CQIC in May 2023.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following Centers for Medicare and Medicaid Services (CMS) protocols. This process assessed the production of

these measures by the health plan to confirm reported information was valid. The performance measure validation found that Healthy Blue was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures (PMs) for the current measure year (2021), the previous measure year (2020), and the change from 2020 to 2021 are reported in *Table 14: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial improvement (>10%) and the rates shown in red indicate a substantial decline (>10%).

Table 14: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	75.00%	75.43%	0.43%
Counseling for Nutrition	63.66%	65.45%	1.79%
Counseling for Physical Activity	62.37%	61.56%	-0.81%
Childhood Immunization Status (cis)			
DTaP	70.07%	67.88%	-2.19%
IPV	86.13%	84.91%	-1.22%
MMR	87.83%	81.75%	-6.08%
HiB	82.00%	79.32%	-2.68%
Hepatitis B	82.73%	82.97%	0.24%
VZV	86.62%	83.45%	-3.17%
Pneumococcal Conjugate	73.72%	72.26%	-1.46%
Hepatitis A	87.10%	80.54%	-6.56%
Rotavirus	72.26%	71.05%	-1.21%
Influenza	45.99%	35.52%	-10.47%
Combination #3	63.26%	62.04%	-1.22%
Combination #7	55.72%	54.26%	-1.46%
Combination #10	31.39%	27.98%	-3.41%
Immunizations for Adolescents (ima)			
Meningococcal	69.10%	67.40%	-1.70%
Tdap/Td	79.08%	75.91%	-3.17%
HPV	30.41%	29.44%	-0.97%
Combination #1	68.86%	66.42%	-2.44%
Combination #2	28.95%	28.47%	-0.48%
Lead Screening in Children (lsc)	72.02%	65.31%	-6.71%

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Breast Cancer Screening (bcs)	51.00%	49.23%	-1.77%
Cervical Cancer Screening (ccs)	59.12%	57.54%	-1.58%
Chlamydia Screening in Women (chl)			
Total	55.56%	56.76%	1.20%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	83.53%	75.74%	-7.79%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	29.61%	25%	-4.61%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	69.00%	68.79%	-0.21%
Bronchodilator	78.05%	81.09%	3.04%
Asthma Medication Ratio (amr)			
Total	73.47%	72.65%	-0.82%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	48.18%	54.74%	6.56%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	77.14%	72.34%	-4.80%
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - Total	77.43%	79.54%	2.11%
Statin Adherence 80% - Total	59.14%	56.25%	-2.89%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	1.14%	3.27%	2.13%
Cardiac Rehabilitation - Engagement1 (Total)	0.57%	2.34%	1.77%
Cardiac Rehabilitation - Engagement2 (Total)	0%	2.34%	2.34%
Cardiac Rehabilitation - Achievement (Total)	0%	0.47%	0.47%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	84.43%	84.91%	0.48%
HbA1c Poor Control (>9.0%)	51.09%	41.61%	-9.48%
HbA1c Control (<8.0%)	44.28%	50.12%	5.84%
Eye Exam (Retinal) Performed	35.52%	35.77%	0.25%
Blood Pressure Control (<140/90 mm Hg)	49.15%	58.39%	9.24%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (Total)	21.93%	23.53%	1.60%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	61.79%	62.54%	0.75%
Statin Adherence 80%	49.43%	54.57%	5.14%

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	49.78%	49.08%	-0.70%
Effective Continuation Phase Treatment	33.59%	32.17%	-1.42%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	36.55%	32.56%	-3.99%
Continuation and Maintenance (C&M) Phase	46.91%	48.12%	1.21%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total - 30-Day Follow-Up	59.46%	62.14%	2.68%
Total - 7-Day Follow-Up	38.99%	40.88%	1.89%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Total - 30-Day Follow-Up	52.41%	54.43%	2.02%
Total - 7-Day Follow-Up	37.24%	39%	1.76%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	35.35%	36.89%	1.54%
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	24.65%	23.95%	-0.70%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	17.17%	17.73%	0.56%
Total - 7-Day Follow-Up	12.18%	13.48%	1.30%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	74.27%	77.10%	2.83%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	59.76%	60.12%	0.36%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	60.00%	50.00%	-10.00%
Pharmacotherapy for Opioid Use Disorder (pod)			
Total	40.89%	38.35%	-2.54%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	60%	59.10%	-0.90%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - Total	45.59%	54.46%	8.87%
Cholesterol Testing - Total	24.92%	38.22%	13.30%
Blood glucose and Cholesterol Testing - Total	23.40%	35.99%	12.59%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.61%	0.53%	-0.08%
Appropriate Treatment for Children With URI (uri)			
Total	86.36%	88.32%	1.96%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			

MEASURE/DATA ELEMENT	Measure Year 2020	Measure Year 2021	PERCENTAGE POINT DIFFERENCE
Total	51.18%	54.67%	3.49%
Use of Imaging Studies for Low Back Pain (lbp)	70.77%	54.67%	-16.10%
Use of Opioids at High Dosage (hdo)	3.41%	2.74%	-0.67%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	20.06%	18.94%	-1.12%
Multiple Pharmacies	3.25%	1.27%	-1.98%
Multiple Prescribers and Multiple Pharmacies	1.95%	0.83%	-1.12%
Risk of Continued Opioid Use (cou)			
Total - >=15 Days covered	4%	3.01%	-0.99%
Total - >=31 Days covered	3.10%	2.16%	-0.94%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
Total	76.80%	76.10%	-0.70%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	41.79%	39.70%	-2.09%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	6.72%	7.84%	1.12%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	56.29%	61.57%	5.28%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	35.10%	37.42%	2.32%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	40.92%	38.01%	-2.91%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	9.52%	9.09%	-0.43%
Initiation of AOD Treatment: Total	43.61%	41.81%	-1.80%
Engagement of AOD Treatment: Total	13.56%	13.22%	-0.34%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	87.59%	89.54%	1.95%
Postpartum Care	78.10%	75.91%	-2.19%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	64.08%	64.86%	0.78%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	47.33%	55.06%	7.73%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	71.17%	68.29%	-2.88%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	41.90%	42.66%	0.76%

Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator

Healthy Blue produces HEDIS rates using software from an NCQA-certified measure vendors. Substantial changes in year-over-year trending were found in five measures.

Influenza rates declined 45.99% to 35.52%, a 10.47% decline; Cardiovascular monitoring for people with cardiovascular disease and schizophrenia declined from 60% to 50%, and the imaging studies for low back pain rate declined 16.10% from 70.77% to 54.67%. Improvement occurred for two metabolic monitoring rates for children and adolescents on antipsychotics. Rates improved for cholesterol testing by 13.3% and for blood glucose and cholesterol testing by 12.59%.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

For the 2023 review, two PIPs were submitted and validated. The non-clinical PIP was CAHPS Customer Service, and the clinical PIP was Comprehensive Diabetes Care. Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. As noted in tables that follow, a summary of each PIP's status and interventions are included.

Table 15: CAHPS - Customer Service PIP

CAHPS - Customer Service	
The aim for this PIP is to improve the Child CAHPS measure: Customer Service Provided Information/Help. This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass. This PIP showed an improvement in the rate for the percentage of members rating customer service from 81.1% in MY 2020 to 83.8% in MY 2021. The documentation showed interventions addressing the response rate and the language barriers as well as customer service-related interventions.	
Previous Validation Score	**Current Validation Score**
88/93= 95% High Confidence in Reported Results	99/99=100% High Confidence in Reported Results
Interventions	

CAHPS - Customer Service
• Oversampling • Provide a Spanish Survey

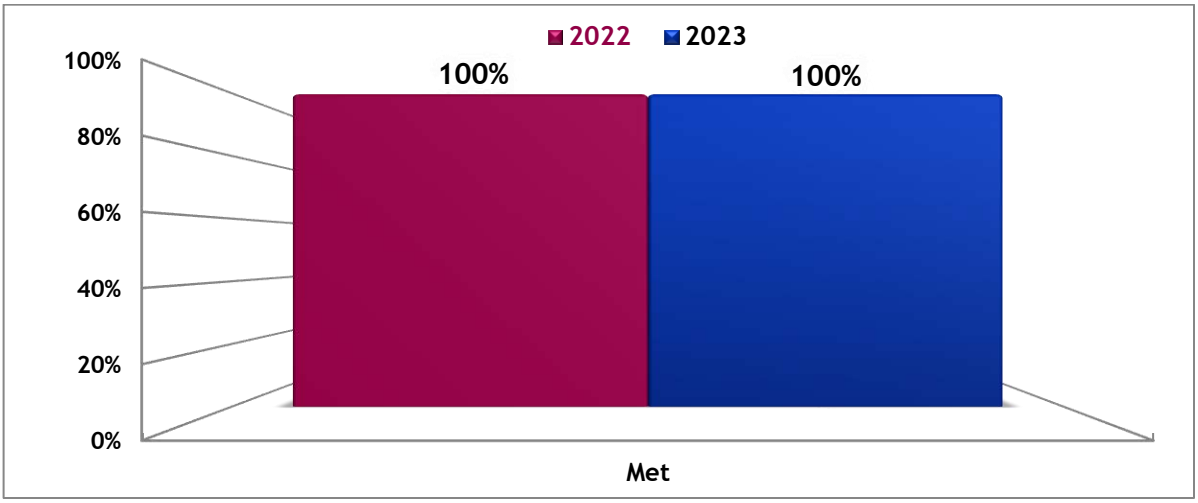
Table 16: Comprehensive Diabetes Care PIP

Comprehensive Diabetes Care	
The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. The rate for poor control (HbA1C > or = 9) declined from 51.09% for baseline to 41.61% remeasurement one, which is improvement, as the goal for this rate is to lower the rate. The retinal eye exam rate increased from 35.52% at baseline to 35.77% at remeasurement one.	
Previous Validation Score	**Current Validation Score**
93/93= 100% High Confidence in Reported Results	99/99= 100% High Confidence in Reported Results
Interventions	
• Targeted text messages and outreach calls to members who have been diagnosed as being Diabetic to ensure the member has their HbA1c screenings and Diabetic Retinal Eye Exams. • Members that become compliant on the following services - A1c test, eye exam, and completion of diabetes survey - will be able to choose gift cards from various platforms. In addition to gift cards, members can receive fresh fruits and vegetables. • Practice Consultants visit (webinars) providers, review their current Gap in Care, provide a PowerPoint presentation with HEDIS information, and answer any questions that the provider may have. • Case Managers offer members assistance with PCP appointments, pharmacy, and any Social Determinants of Health needs.	

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

Healthy Blue continues to meet all the requirements in the Quality Improvement section of the review as noted in *Figure 6*.

Figure 6: Quality Improvement Findings



Strengths

- The Performance Measures were compliant with the HEDIS technical specifications for rate calculations.
- All Performance Improvement Projects received validation scores within the High Confidence range.

Weaknesses

- Healthy Blue's website contained information regarding the QI Program; however, this information was from 2021 and therefore, outdated.

Recommendations:

- Update the QI information on the Healthy Blue's website.

E. Utilization Management

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

Healthy Blue's Utilization Management Program Description outlines the staff responsibilities, scope, and objectives for physical health and behavioral health services. The Pharmacy Program Description and various policies provide an overview and structure of Healthy Blue's pharmacy program.

Healthy Blue's pharmacy benefit manager, CarelonRx, is responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities. Onsite discussion revealed that CarelonRx changed their

name from IngenioRx in January 2023. Despite the recent name change, the Pharmacy Program Description continues to reflect IngenioRx as the pharmacy benefit manager. During onsite discussion, the health plan stated they are in the process of transitioning their documentation to reflect the updated name.

The Director of Healthcare Management is responsible for ensuring best practices and quality service delivery of UM and Care Management services. The Medical Directors provide clinical oversight of UM decisions, conduct Level II Reviews, and serve on various committees. The Pharmacy Director provides oversight of the pharmacy program. The Behavioral Health Medical Director provides oversight for the Behavioral Health UM Programs and is responsible for case consultations, second-level reviews, and the development and implementation of behavioral health policies.

The UM review staff are licensed clinicians that conduct initial clinical reviews for authorization requests. Nonclinical staff provide support to the clinicians by assisting with outbound calls, developing a daily census report, and coordinating peer reviews as needed. Supervision for the UM clinicians and nonclinical staff is provided by the Healthcare Management Team Leaders, who have several role responsibilities such as queue management and consultations.

Coverage and Authorization of Services

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

UM Reviewers utilize evidenced based criteria such Milliman Clinical Guidelines (MCG), Medical Policies, Carelon Medical Benefits Guidelines, State Guidelines, and more to make clinical coverage decisions. Also, individualized member characteristics and relevant clinical information are utilized when making UM determinations. To ensure there is no partiality or bias in the review process, the Medical Directors and licensed clinical staff recuse themselves from involvement in any UM decisions when there is a conflict of interest. Clinical reviewers have access to peer clinical reviewers or health professionals with the same or similar clinical expertise for consultations as needed.

Healthy Blue utilizes several methods to measure consistency of clinical application and quality assurance for clinical reviewers in managing authorization requests. Annually, Inter Rater Reliability testing is conducted to ensure consistency and accuracy of medical necessity criteria. Based upon the 2021 Inter Rater Reliability results, the UM Reviewers and Physicians received passing scores. Also, the Process Improvement Team ensures quality assurance through conducting monthly focused review audits to analyze turnaround time, consistency in clinical application, and identify any trends or deficiencies. The feedback is provided to UM Leadership for training suggestions and support as needed. Also, the findings are presented to the Service Quality Improvement Committee for review.

The review of a sample of approval files reflects application of appropriate clinical criteria in making clinical determinations with approval decisions promptly communicated to the respective parties.

The review of a sample of denial files reflected timely determinations and a clear explanation of the reasoning for the adverse benefit decision and guidelines for the appeal process.

The Preferred Drug List (PDL) identifies formulary restrictions by indicating medications requiring prior approval, limitations, and/or step therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL. Changes to the PDL are posted on the website, and the change document includes the date the notice was posted and the effective date for the change, as required by the *SCDHHS Contract, Section 4.2.21.2.3*. For the 2022 EQR, CCME found that the health plan did not meet this requirement. Following the 2022 EQR, Healthy Blue updated their process for posting PDL changes to the website. For this EQR, CCME found Healthy Blue met SCDHHS' requirement for posting negative PDL changes. The table that follows is an overview of the previous year's deficiency and the health plan's response.

Table 17: Previous Deficiencies and Quality Improvement Plan

Standard	EQR Comments
V B. Medical Necessity Determinations	
6. Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	The Pharmacy Program Description explains that IngenioRx is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities. Healthy Blue's website contains information regarding covered prescriptions including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. It was not clear when the changes were posted to the website. Page 10 of the Pharmacy Program Description indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the SCDHHS Contract requires the change be published on the website at least 30 days prior to implementation. *Quality Improvement Plan: Update the PDL change document posted on the website and include the date the change document was posted. Also, update the Pharmacy Program Description to indicate that changes are published on the*

Standard	EQR Comments
	website at least 30 days prior to implementation as required by the SCDHHS Contract, Section 4.2.21.2.1 and 4.2.21.3.
Healthy Blue Response: The Preferred Drug List (PDL) Member Formulary Change Notice posted on the Healthy Blue website includes the date the change document was posted. The Pharmacy Program Description, page 10, includes language regarding compliance with regulatory requirements and refers to Policy A03 - Medicaid Formulary System Process in which the *SCDHHS Contract requirements, Sections 4.2.21.2, 4.2.21.2.1-5* are specified on pages 14-15. See attachments: • QIP 3a_Website Member Formulary Change Notice • QIP 3a1_Screen Shot Member Website Posting PDL Change Date • QIP 3a2_Screen Shot Provider Website Posting PDL Change Date • QIP 3b_Pharmacy Services Program Description Page 10 • QIP 3c_Policy A03 - Medicaid Formulary System Process	

Appeals

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

Healthy Blue's appeal guidelines and procedures are outlined in the UM Program Description, Provider Manual, Member Handbook, and various policies. Standard appeals are processed within 30 days and expedited appeals are processed within 72 hours. Policy SC_GAXX_051, Member Appeals Process, identified that if a standard appeal determination is not made within the established timeframes, the member's request would be approved. However, the policy does not address that expedited appeals will be considered approved if an appeal determination is not made within the established timeframes.

Appeal quarterly reports are presented during the SQIC and trends and opportunities for improvement are discussed. A yearly summary is also included in the UM Annual Evaluation and Quality Management Program Evaluation.

During the 2022 EQR, issues were identified in the sample appeal file review regarding Healthy Blue not providing copies of the case files to members within 10 days according to policy standards, appropriate physician review with same or similar specialty, and requiring a written request to follow an oral appeal request. CCME found that these issues were corrected. *Table 18* provides an overview of the deficiency and Healthy Blue's response.

Table 18: Previous Deficiencies and Quality Improvement Plan

Standard	EQR Comments
V C. Appeals	
2. The MCO applies the appeal policies and procedures as formulated.	CCME's review of appeal files concluded that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. The following are issues identified with the appeal files: •Healthy Blue's Policy SC_GAXX_051, Member Appeal Process, indicates the member or authorized representative is mailed a copy of the case file within 10 calendar days of receipt of the appeal. There were nine files where the case file was not sent within the 10-day timeframe or was not sent at all. This was an issue identified during the 2021 EQR. •Three files required the member to submit the appeal request in writing after requesting the appeal orally, even though this is no longer a requirement. •The physician who made the appeal decision for three files was not the same or similar specialty as the requesting provider. *Quality Improvement Plan: Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy, SCDHHS Contract, and federal regulations. Implement interventions to address the barriers.*
Healthy Blue Response: The Healthy Blue Grievance and Appeals Department root cause analysis and review of Policy SC_GAXX_051 identified appropriate interventions to address the Quality Improvement Plan barriers. • Our review indicated that a prompt, formalized intake process is essential to meeting the case file timeliness standard and that staffing changes have sometimes contributed to prior improvements being lost. Healthy Blue has drafted and put into practice a South Carolina Medicaid Case File Assignment Desktop Process to ensure a timely and consistent process to provide member case files for standard appeals within 10 calendar days. • While Healthy Blue no longer requires written follow-up when a member files a verbal appeal, it was identified that outdated letters were being utilized, therefore, all letters referring to the written follow-up requirement are no longer in use as of May 1, 2022. • It was determined that a routing error contributed to the same or similar provider specialty reviewer standard not being met. The Healthy Blue Grievance and Appeals Department is implementing regular appeal staff training and reminders as well as a component of quality assurance letter review. Additionally, Healthy Blue Compliance has a quarterly audit process in which random appeal files are selected and reviewed for compliance with contract and regulatory standards. Any identified concerns are discussed with business owners to identify appropriate next steps. See attachments: • QIP 4 and 6_SC Medicaid Case File Assignment Desktop Process • QIP 4 and 6_Policy SC_GAXX_051 Page 4 Redline	

In review of the appeal files, CCME found the appeal files were processed timely. However, issues were identified with the acknowledgement letters and appeal extension letters for expedited appeal requests. These letters contained incorrect timeframes for appeal resolution. The files indicated in the acknowledgement letter that the appeal will be processed in 30 days and the appeal letter extension timeframe informed the member that the appeal will be processed 44 days from date of appeal submission. This does not coincide with contractual timeline regulations for expedited appeals of 72 hours for appeal resolution and a total of 17 days for expedited appeal extensions.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

The Complex Case Management Program Description and various policies provide a descriptive overview and process of Healthy Blue's Case Management and Care Coordination Program.

Members are referred for case management services through various referral sources such as internal referrals, provider referrals, self-referrals, health information exchanges, and predictive modeling. Policy GBD_CM_102, Complex Case Management, referenced Policy GBD_CM_01, Member Identification and Assessment of Populations, as a policy that provided additional information on the member referral process. However, during the onsite discussion, Healthy Blue reported that this policy is no longer active.

Members with co-occurring behavioral and medical needs are provided specialized care management services. The Behavioral Health and Physical Health Case Management Staff identify members with co-occurring behavioral health and medical management needs and work collaboratively to ensure the total needs of the member are met through efforts such as co-management of cases, joint visits, and coordination of care to community resources. Also, based upon the member's prevalent behavioral health or medical needs, a lead behavioral health or physical health case manager may provide primary care coordination.

Healthy Blue has developed methods to increase member engagement in the care management program such as conducting telephonic follow up during evening hours, developing community partnerships, providing education, and offering incentives to members. The health plan also has methods for quality assurance and promoting wellness for members with complex needs. The Population Health Workgroup, comprised of clinical and nonclinical staff, provides oversight of the population health program. The objective of the workgroup is to conduct an analysis of the most prevalent diagnoses within the member population and develop strategies to promote disease management. Additionally, in the Complex Care Management Program Description (page 11), a Clinical Advisory Group was described as a composition of clinical and nonclinical leadership that

meets quarterly and provides oversight. However, during the onsite discussion, the health plan identified that there was not currently a Clinical Advisory Group.

The review of a sample of Healthy Blue's care management files indicated that care management activities, such as conducting care management assessments, treatment planning, follow-up, and linkage to appropriate community resources, are conducted as required.

Figure 7: Utilization Management Findings

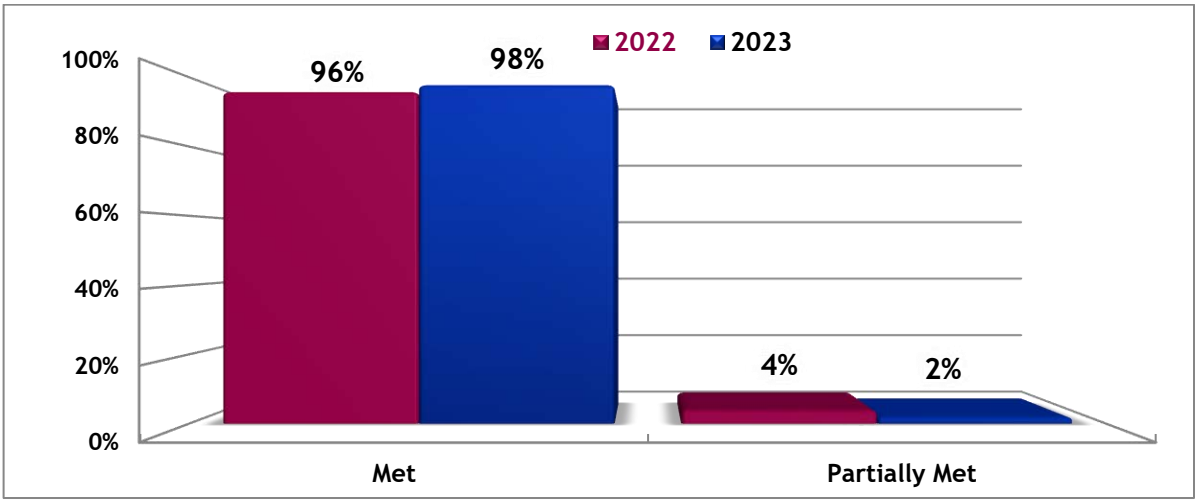


TABLE 19: Utilization Management Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Medical Necessity Determinations	Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- Healthy Blue's Performance Improvement and Enhancement Team conducts monthly random case sample audits to ensure consistency in clinical application and timeliness of authorization processing by clinical reviewers.
- Healthy Blue's Population Health Work Group is designed to identify barriers for member engagement in the care management program and develop strategies to increase member wellness and engagement.

- Denial files were completed timely and provided a clear explanation for the reasoning for the adverse benefit decision.
- Healthy Blue has developed networking relationships with community partners and provides incentives to members to increase member engagement in the care management program.

Weaknesses

- CarelonRx changed their name from IngenioRx in January 2023; however, the Pharmacy Program Description continues to reflect IngenioRx as the pharmacy benefit manager.
- Policy SC_GAXX_051, Member Appeals Process, does not indicate that expedited appeals will be considered approved if an appeal determination is not made within the established timeframes.
- In the review of a sample of appeal files, issues were noted in that acknowledgement letters and appeal extension letters communicated incorrect timeframes for resolution.
- The Complex Care Management Program Description provided an overview of a Clinical Advisory Group that provides oversight of the care management program. However, during the onsite discussion, the health plan identified that there was not currently a Clinical Advisory Group.
- Policy GBD_CM_102, Complex Case Management, referenced Policy GBD_CM_101, Member Identification and Assessment of Populations, to provide additional information on the member referral process. However, during the onsite discussion, Healthy Blue reported that this policy is no longer active.

Quality Improvement Plans

- Ensure the acknowledgement and appeal extension letters communicate the correct timeline for resolution.

Recommendations

- Update all documentation and communication to reflect the Pharmacy Benefit Manager's name change to CarelonRx.
- Consider adding in Policy SC_GAXX_051, Member Appeal Process that an expedited appeal determination will be deemed approved if a determination is not made within the established timeframes.
- Remove reference to Clinical Advisory Group within the Complex Care Management Program Description as this is identified as not providing oversight of the care management program.

- Remove reference to Policy GBD_CM_101, Member Identification and Assessment of Populations in Policy GBD_CM_102, Complex Case Management (Care Compass) as this policy is no longer active.

F. Delegation

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

Delegation agreements are in place between Healthy Blue/Amerigroup and the entities listed in *Table 20: Delegated Entities and Services*.

Table 20: Delegated Entities and Services

Delegated Entities	Delegated Services
• CarelonRx • CaremarkPCS (CVS)	Pharmacy benefit management
• AnMed Health • HCA Physicians Services Group • Medical University of South Carolina • Prisma Health • Roper St. Francis Physician's Network • Self Regional Healthcare • South Carolina Department of Mental Health • Spartanburg Health/Regional Health Plus • Tenet (HCS Physicians) • VSP Vision Care	Credentialing

The Utilization Management - Medicaid Delegation and Oversight policy and Policy MCD-10, Credentialing Delegation, address processes for delegating health plan activities to outside entities. Prior to approving an external entity to conduct health plan activities, a pre-delegation assessment is conducted to determine the potential delegate's ability to comply with contractual, health plan, federal, and/or accreditation requirements and standards. Upon approval of delegation, a written delegation agreement is implemented that specifies delegate activities and responsibilities, reporting requirements, actions that may result from non-compliant or sub-standard performance, etc.

Each delegate is responsible for routine reporting to the health plan and is subjected to a formal annual evaluation to assess ongoing compliance with the delegation agreement and applicable standards for the activities delegated.

Oversight documentation was submitted for the delegates conducting activities for Healthy Blue. The documentation confirmed annual oversight was timely. Any identified issues were documented and resulting corrective actions were identified, along with

recommendations as appropriate. Audit tools for the various delegated functions were thorough and included all requirements. It was clear that Healthy Blue addressed the deficiency identified during the previous EQR related to credentialing file review worksheets that did not indicate that delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges. See *Table 21: Previous Delegation QIP Items* for the deficiency and Healthy Blue's response.

Table 21: Previous Delegation QIP Items

Standard	EQR Comments
V I. DELEGATION	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Documentation was submitted for all delegated entities showing annual and/or pre-delegation assessment conducted in the last year. The documentation shows recommendations and corrective actions were implemented with the delegates when appropriate. For credentialing delegates, the file review worksheets do not provide evidence that the delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges. *Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for compliance with initial credentialing timeframe requirements and for ensuring applicable providers have admitting privileges or an admitting arrangement. These elements should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.*
Healthy Blue Response: The Credentialing File Review Workbook (Delegated Credentialing Audit Tool) is updated, effective May 13, 2022, to reflect that Credentialing and Recredentialing Delegates are monitored for compliance with the following elements: • HOSPITAL PRIV/ADMIT PLAN – Initial Credentialing and Recredentialing Tab • Credentialing Timeframe Requirements Met - Initial Credentialing Tab See attachment: QIP 5_Copy of Delegated Credentialing Audit Tool - Healthy Blue	

Documentation of oversight is reported routinely through the Delegation Operations Committee (DOC), Credentialing Committee, and other applicable committees.

As noted in *Figure 8: Delegation Findings*, 100% of the Delegation standards were scored as "Met."

Figure 8: Delegation Findings

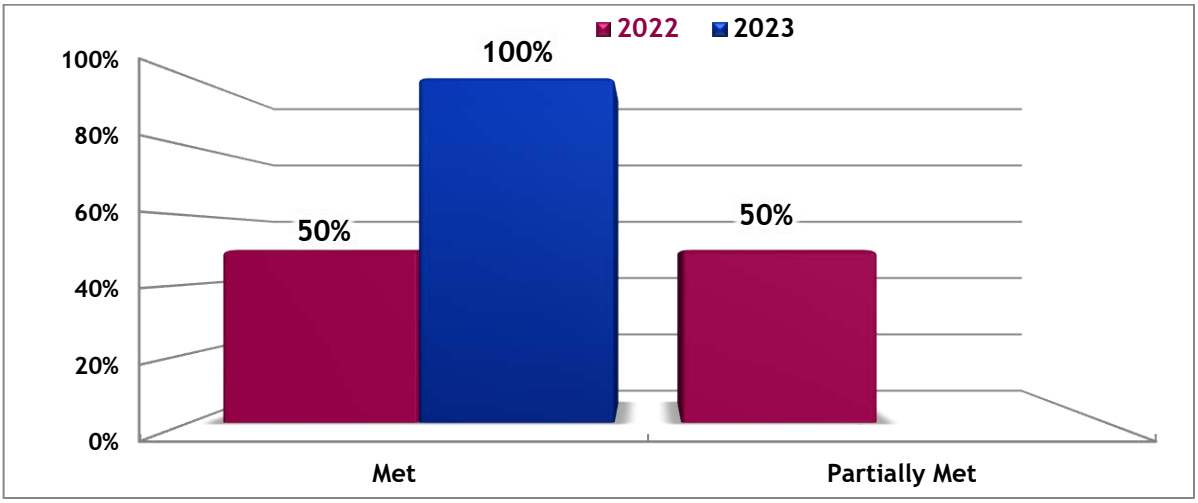


Table 22: Delegation Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 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 2022 to 2023.

Strengths

- Policies and procedures detail requirements for pre-delegation assessments, implementation of delegation agreements, and ongoing monitoring and evaluation of delegates.
- Written delegation agreements implemented with each delegated entity specify the delegated activities, delegate responsibilities, reporting requirements, consequences of non-compliance or sub-standard performance, etc.
- Documentation of delegate oversight confirmed annual audits are conducted and audit tools address all requirements for the delegated functions.

G. State Mandated Services

42 CFR Part 441, Subpart B

Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring – SC, and Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services – SC, describe processes for evaluating provider compliance with preventive care recommendations, including immunizations. Healthy Blue monitors providers' compliance with provision of recommended EPSDT services and immunizations for members. This monitoring is conducted primarily through the annual medical record audit. In addition, HEDIS gap-in-care data is monitored on a monthly basis.

Healthy Blue provides all core benefits specified by the *SCDHHS Contract*.

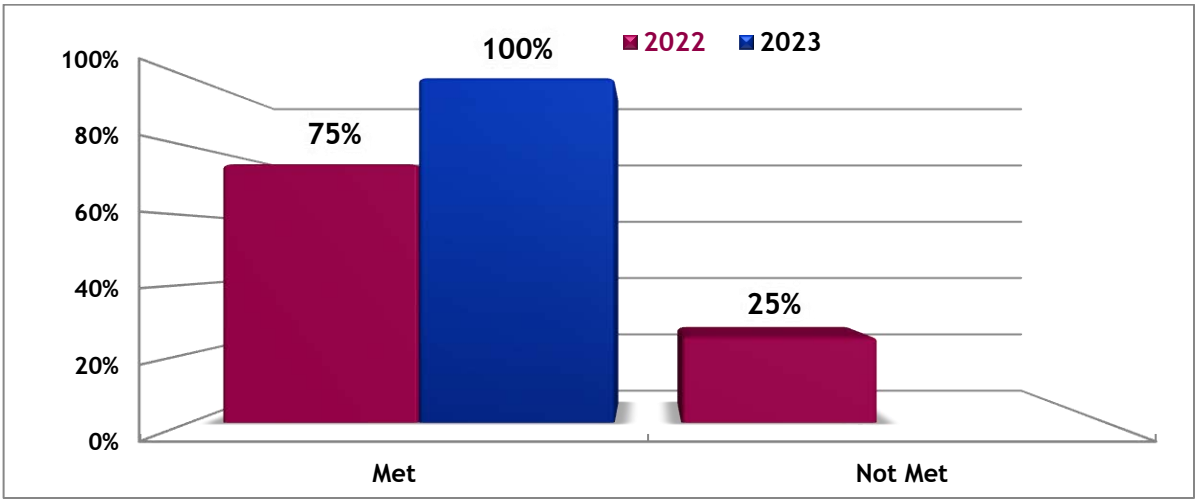
Findings of the 2022 EQR included that a deficiency from the 2021 EQR related to not consistently following the member appeal process outlined in health plan policy was not corrected. See *Table 23: Previous State Mandated Services QIP Items* for specific information about this deficiency and Healthy Blue's response. The current EQR confirmed that all deficiencies identified during the 2022 EQR were addressed.

Table 23: Previous State Mandated Services QIP Items

Standard	EQR Comments
VII. State Mandated Services	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10-day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process. *Quality Improvement Plan: Implement Quality Improvement Plans from the EQR to address all identified deficiencies.*
Healthy Blue Response: Please refer to the response provided for QIP item #4 (above). The Healthy Blue Grievance and Appeals Department is implementing continuous Grievance and Appeal staff education to ensure consistency when applying the Member Appeals Process.	

As noted in *Figure 9: State Mandated Services*, 100% of the standards in the State Mandated Services section of the review were scored as "Met."

Figure 9: State Mandated Services



Strengths

- Provider compliance with provision of recommended immunizations and EPSDT services is monitored through the annual medical record review audit and by monitoring HEDIS data.
- All core benefits are provided to members.
- All deficiencies from the previous EQR were addressed.

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

March 13, 2023

Mr. Tim Vaughn
President and COO
Healthy Blue
4101 Percival Road
Columbia, SC 29229

Dear Mr. Vaughn:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the Annual External Quality Review (EQR) of Healthy Blue 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 the Healthy Connections 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), a virtual 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 two day virtual onsite will be conducted on **May 17th and 18th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **March 27, 2023.**

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 2023

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. Please provide a list of all current employees, the employees title, and credentials.

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

Excel Spreadsheet Format

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

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

7. A 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, Population Health Management, and Pharmacy Programs.

10. The Quality Improvement work plans for 2022 and 2023.

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 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. Please provide the over and underutilization summary report(s) and the quarterly or monthly monitoring reports.

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 April 2022 through March 2023. 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 surveys (i.e., CAHPS and ECHO), a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

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 April 2022 through March 2023.

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

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

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.**
    - **i. Please include the point value, and index scores for the SCDHHS withhold measures.**

36. Electronic copies of the following files:
    - a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    - b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    - c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of April 2022 through March 2023. Include any medical information and physician review documentation used in making the denial determination.
    - d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of April 2022 through March 2023, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or

hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

- **should be organized and uploaded to the secure CCME EQR File Transfer site at:** https://eqro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.

2. Please provide an update on any changes that have occurred since the desk materials were uploaded (3/27/23). Example, any policies that have changed or have been updated, staff changes, etc.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**CAHPS- NON CLINICAL**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sampling technique followed HEDIS guidelines.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Methods are used to mitigate bias.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sufficient sample, based on HEDIS methodology, was used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measure is defined.
5.2 Did the indicators measure changes in health status, functional status, enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to enrollee satisfaction.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
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**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rate is reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurements are displayed.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation and interventions.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	The CAHPS PIP showed an improvement in the rate for the percentage of members rating customer service from 81.1% in MY 2020 to 83.8% in MY 2021.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Rate improved from 81.1% in MY 2020 to 83.8% in MY 2021.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	**99**
Project Possible Score	**99**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the 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:	**Healthy Blue**
Name of PIP:	**COMPREHENSIVE DIABETES CARE - CLINICAL**
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	Data analysis and study rationale are reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim is reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addresses key aspects of enrollee care and service.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP includes all enrollees in relevant population.
STEP 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	Sampling technique followed HEDIS guidelines.
4.2 Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	Methods are used to mitigate bias.
4.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	Sufficient sample, based on HEDIS methodology, was used.
STEP 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Measures are defined.
5.2 Did the indicators measure changes in health status, functional status, enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators are related to functional status and processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods are documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources are documented.

Component / Standard (Total Points)	Score	Comments
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**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan noted as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and remeasurement values are reported.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation and interventions.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	For the CDC PIP, there are two indicators: HbA1C poor control and retinal eye exam rates. The rate for poor control (HbA1C > or = 9) declined from 51.09% for baseline to 41.61% in remeasurement 1, which is improvement, as the goal for this rate is to lower the rate. The retinal eye exam rate increased from 35.52% at baseline to 35.77% at remeasurement 1.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions to improve A1C and eye exam adherence.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing is not conducted.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	99
Project Possible Score	99
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the 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 PM Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**MY2021/RY2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2021/RY2022 TECHNICAL SPECIFICATIONS

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

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

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	**Met**	Numerator sources were accurate.

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**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall assessment			Submitted measures were prepared according to measure specifications and presented fairly.

VALIDATION SUMMARY			
Element	**Standard Weight**	**Validation Result**	**Score**
G1	10	Met	10
D1	10	Met	10
D2	5	Met	5
N1	10	Met	10
N2	5	Met	5
N3	5	Met	5
N4	5	Met	5
N5	5	Met	5
S1	5	Met	5
S2	5	Met	5
R1	10	Met	10

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2022
Review Performed	2023

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Adult response rate was 10.5%, which is a decline from the previous year of 11.99% with 188 surveys completed out of the initial sample of 1,809. This was below the NCAQ target response rate of 40%. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021) ***Recommendation:*** *Continue oversampling and work plan interventions to increase response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

Results Elements		Validation Comments and Conclusions
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS 2022 Adult CAHPS Survey Results Report (MY 2021)

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2022
Review Performed	2023

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
3.3	Review that the sampling method appropriate to the survey purpose.	**MET**	Sampling method was conducted according to specifications. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The child surveys met the minimum sample size of 411 valid surveys with a total of 454 completed out of 3,185 and the response rate was 14.3% which is a decline from the previous year's rate 17.07%. The response rate is below the NCQA target response rate. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021) ***Recommendation:*** *Continue oversampling and work plan interventions to increase response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

Results Elements		Validation Comments and Conclusions
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS 2022 Child CAHPS Survey Results Report (MY 2021)

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2022
Review Performed	2023

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience is identified in the report. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards.	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits?	**MET**	The quality plan is documented. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The CCC survey sample was below the target of N=411 with 328 completed surveys out of 2,673 for a response rate of 12.32%, which is a decline from the previous rate of 22.24%. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021) ***Recommendation:*** *Continue oversampling and work plan interventions to increase response rates.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

Results Elements		Validation Comments and Conclusions
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS 2022 Child CCC CAHPS Survey Results Report (MY 2021)

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Healthy Blue
Collection Date:	2023

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy MCD-16, Policy Development, Review, and Management, indicates that policies are reviewed annually by the Compliance Committee and are available to all Healthy Blue staff on a shared network drive.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Tim Vaughn is Healthy Blue's President and Chief Operating Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Chief Financial Officer (CFO);	X					Jennifer Thorne is the Chief Financial Officer.
1.3 * Contract Account Manager;	X					Amy Bennett is the Contract Account Manager.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					The Claims and Encounter Managers are Kraig Dalton (Claims) and John Hodges (Encounters).
1.4.2 Network Management Claims and Encounter Processing Staff,						
1.5 Utilization Management (Coordinator, Manager, Director);	X					Bryan Hawkins, RN, BSN is the Director of Utilization Management.
1.5.1 Pharmacy Director,	X					Julie Hernandez, PharmD, is the Pharmacy Director.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					Onsite discussion indicated that twelve case management staff are located in South Carolina with one additional case manager located outside of South Carolina.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Shana Hunter is the Director, Quality Management.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Sandy Sullivan is the Provider Services Manager.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7.1 *Provider Services Staff,	X					Onsite discussion indicated that Provider Services consists of two teams in South Carolina, Provider Relations and Provider Education. A total of 19 staff are located in SC).
1.8 *Member Services Manager;	X					The Member Services Manager is Letitia Lindsay.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					The Medical Director is Imtiaz Khan, D.O.
1.10 *Compliance Officer;	X					Billy Quarles is the Compliance Officer.
1.10.1 *Program Integrity Coordinator;	X					Debra Teeter serves as the Program Integrity Coordinator for Healthy Blue.
1.10.2 Compliance/ Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					Melanie Joseph, J.D. is Healthy Blue's legal representative.
1.13 *Behavioral Health Director;	X					Wendy Graham, LPC, LAC, LCMHC is Healthy Blue's Behavioral Health Director.
1.14 *Program Integrity FWA Investigative/Review Staff.	X					Debra Teeter is identified as the Program Integrity Coordinator/Investigator Sr./Onsite Post-Payment Reviewer for Amerigroup. Healthy Blue reported a total of three Special Investigative Unit (SIU) investigators located in South Carolina.
2. Operational relationships of MCO staff are clearly delineated.	X					The operational relationships of staff are clearly outlined.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Healthy Blue exceeds the State requirements by processing 98% of claims within 14 days and sets its internal standard at 98% of claims paid within 30 days, and 99% of claims paid within 90 days.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Healthy Blue currently accepts and generates almost 100% of its transactions electronically and uses an Electronic Data Interchange (EDI) system to enter claims, which are coded using industry standard coding schemes.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					To link enrollment and demographic data, Healthy Blue uses a universal member ID number. The universal member ID is common throughout the MCO's systems and is validated monthly to ensure data is linked correctly.
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					Healthy Blue uses NCQA-certified software for HEDIS reporting. ISCA documentation states it's the HEDIS reporting process is audited at least five times each year. If an issue is found during an audit, the MCO states that it has processes to isolate the issue and implement corrective action.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Healthy Blue provided several organizational handbooks that summarize the organization's policies for access management, data security, and system security. The policies adhere to industry best practices and, based upon timestamps, appear to be regularly reviewed and updated.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Healthy Blue has established policies for access management, data security, and system security. The implementation of these policies and the backing procedures have been audited and certified to be HITRUST (Health Information Trust Alliance) compliant.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Healthy Blue has both an extensive Disaster Recovery plan and a detailed business continuity plan. Disaster Recovery testing was recently performed to validate the plan. The Disaster Recovery test was completed successfully in a rather short time span. The organization identified a couple of small issues that it has already begun taking action to correct.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Compliance Plan describes Healthy Blue's commitment to providing staff with hands on knowledge and decision-making capabilities regarding program integrity and to coordinating Fraud, Waste, and Abuse efforts with the SCDHHS Program Integrity/SUR Division.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Healthy Blue's values and principles of ethics and compliance are outlined in the Our Values document.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The 2023 Compliance Plan, Organizational Chart, and the Key Personnel List identify the Compliance Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The 2023 Compliance Committee Charter provides an overview of the committee's purpose and describes processes for the establishment of a quorum and responsibilities of members.
2.5 Compliance training and education;						The Compliance Challenge (compliance training) is conducted upon hire and annually for employees and contractors.
2.6 Lines of communication;						A confidential telephone line is available for Healthy Blue employees, contractors, providers, members, and any other interested person to report suspected cases of fraud, waste, abuse, criminal activity, conflicts of interest, and breaches of ethical business conduct standards.
2.7 Enforcement and accessibility;						Mechanisms for addressing instances of compliance violations include, as appropriate, education and training, progressive discipline, provider sanction or termination of contract, and repayment if the conduct resulted in improper reimbursement.
2.8 Internal monitoring and auditing;						Internal monitoring activities are outlined in the Compliance Plan and include ongoing assessment of program risk areas, establishing metrics for self-reporting, and reviewing corrective actions taken to address identified risks.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Response to offenses and corrective action;						
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						Pre-employment background checks are conducted for all potential employees, providers, and contractors. Federal and state exclusion databases are reviewed to ensure they have not been deemed ineligible to participate in the program.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Cases of misconduct or non-compliance related to the Healthy Blue program are reviewed by the SIU and, when applicable, reported to SCDHHS and other applicable entities.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy RX LOCK 43150, Lock-In SC Medicaid, details processes related to the Pharmacy Lock-In Program, which is designed to reduce inappropriate utilization, reduce costs, and improve quality of life through enhanced coordination of care for members identified as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						over-utilizing prescribers, medications, and pharmacies.
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Policy MCD-09, Privacy and Confidentiality, outline how Healthy Blue ensures compliance with HIPAA and privacy regulations. The policy details processes for implementing privacy and security regulations for Health Blue.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and		X				Credentialing processes and requirements are documented in the Healthy Blue Credentialing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
recredentialing of health care providers in a manner consistent with contractual requirements.						Program Plan and policies, including Policy MCD-04, Initial Credentialing, Policy MCD-05, Recredentialing, and Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing. Delegation of credentialing activities is addressed in Policy MCD-10, Credentialing Delegation. Onsite discussion confirmed practitioners may appeal credentialing denials when the denial is not related to loss of licensure, sanctions, or exclusions. However, Policy MCD-04, Initial Credentialing, states only that providers may appeal when "there is an absence of explanatory documentation or the provider has responded affirmatively to the Health and History section questions of the application." Policy MCD-06, Health Care Delivery Organizations - Credentialing/Recredentialing, does not address: • Provider appeal rights related to credentialing and recredentialing. • Processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing. • Provider rights and processes for ensuring a non-discriminatory credentialing process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Processes for verifying that organizational providers have a current Medicaid ID number. *Quality Improvement Plan: Revise Policy MCD-04 to include detailed information about the circumstances under which a provider may appeal a denial of credentialing. Revise Policy MCD-06, Health Care Delivery Organizations-Credentialing / Recredentialing, to address provider appeal rights related to credentialing and recredentialing; processes for notifying the Medicaid Provider Contracting Department, the Medicaid Compliance Department, and SCDHHS of a denial of credentialing; provider rights and processes for ensuring a non-discriminatory credentialing process; and processes for verifying that organizational providers have a current Medicaid ID number.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					As noted in the Healthy Blue Credentialing Program Plan, the Credentialing Committee directs the Credentialing Program and is ultimately responsible for approving or denying credentialing/recredentialing applications. The Credentialing Committee meets monthly. The quorum is defined as the presence of at least three voting committee members,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						comprised of a variety of network providers. The Committee Membership List indicates voting members of the Credentialing Committee include practitioners with specialties of Family Practice, Internal Medicine, Pediatrics, OB/GYN, Pulmonology, Chiropractic, Dentistry, and two Nurse Practitioners. The committee is chaired by the Associate Medical Director, who votes only to break a tie. Review and approval of "clean" credentialing files are delegated by the committee to the Medical Director. Review of Credentialing Committee minutes from February 2022 through February 2023 confirmed that a quorum was present for each meeting; however, three voting members did not meet the attendance requirement of 60% of meetings. *Recommendation: Reinforce attendance expectations for members of the Credentialing Committee. Consider recruiting an additional OB/GYN provider for membership on the committee.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					No issues were identified in the sample of initial practitioner credentialing files reviewed.

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;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
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					
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					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					No issues were identified in the sample of recredentialing files for practitioners.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
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					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					The Credentialing Committee or Medical Director may restrict, suspend, or terminate network providers when quality of care issues or federal sanctions are identified or the provider fails to meet credentialing standards. Policy MCD-07, Professional Practitioner – Restriction,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Suspension or Termination, describes these processes and includes information about provider notification of actions taken and appeal rights. The policy also addresses reporting to SCDHHS, the NPDB, state licensing board, and other appropriate entities.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					No issues were identified in the sample of initial credentialing and recredentialing files for organizational providers.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Healthy Blue conducts checks for provider sanctions and exclusions at initial credentialing, recredentialing, and monthly between credentialing cycles, as described in Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination. This monitoring includes the: • National Practitioner Data Bank (NPDB) • Office of the Inspector General's List of Excluded Individuals/Entities (LEIE) • System for Award Management (SAM) • SCDHHS South Carolina Excluded Providers' Spreadsheet • Licensing Boards • Social Security Administration's Death Master File • SC List of Providers Terminated for Cause Identified sanctions are presented to the Credentialing Committee for a determination of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						any further actions, such as restriction, suspension, or termination of the provider's network participation.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO 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 MCD-11, Medicaid Access and Availability, defines the geographic access requirement for primary care providers (PCPs), including Family Practitioners, General Practitioners, Pediatricians, and Internal Medicine providers, as 90% of the population with access to one PCP within 30 miles/45 minutes. The Healthy Blue Network Analyses dated February 22, 2023 show the evaluation of time and distance access on a county-by-county basis for all provider types. The analyses indicate 100% of members have the required access to PCPs.
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-		X				Policy MCD-11, Medicaid Access and Availability, defines the geographic access requirement for specialty providers as 90% of the population with access to a specialty provider within 50 miles/75 minutes and to an OB/GYN within 30 miles. For

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
network specialist with no benefit penalty.						hospitals, the policy defines the standard as one hospital within 50 miles/75 minutes for 90% of the population. The Healthy Blue Network Analyses for Driving Time and Driving Distance reflected measurement of time and distance access for all required Status 1 providers except Rehabilitative Behavioral Health providers. *Quality Improvement Plan: Ensure Geo Access mapping includes all required Status 1 provider types. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Healthy Blue evaluates the geographic adequacy of its network at least annually by conducting Geo Access mapping and analyzing results of CAHPS Surveys, member complaints, and grievances. As noted in Policy MCD-11, Medicaid Access and Availability, network reports are submitted to SCDHHS at the frequency "defined by the MCO contract and the SCDHHS Policy and Procedure manual." Onsite discussion confirmed the Geo Access mapping and reporting to SCDHHS occur at least twice a year.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment,	X					Healthy Blue has an established Cultural and Linguistic Program to ensure "customer-focused and customer-driven services that are both

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
foreign language/cultural requirements, and complex medical needs.						culturally competent and linguistically appropriate" for members, including those with diverse cultures and beliefs, limited English proficiency, and limitations in literacy, hearing, speech, and vision. The Culturally and Linguistically Appropriate Services Policy provides comprehensive information about the program. The Provider Manual includes information about cultural competency, and the health plan's website links the user to the "My Diverse Patients" website, which includes learning modules, resources, and tools to further provider understanding of cultural competency.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					As noted in the 2022 Quality Management Program Evaluation, Healthy Blue conducted an evaluation of network adequacy that included data from the following: • 2022MY Availability Report • 2022MY Accessibility Report • 2022MY Member Experience Report • 2022MY Out of Network (OON) utilization requests and utilization data As a result of the evaluation, opportunities for improvement were identified and interventions were enacted to address the opportunities. These interventions included:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Re-educating providers who were not meeting access standards, balance billing members, and referring members to non-participating providers. • Continuing to address access and availability standards and requirements as well as referring to participating providers in new provider orientation and ongoing provider education activities. • Addressing specialist to PCP communication in newsletter articles. Additional member-focused interventions included: • Creating member materials highlighting use of the member website, telehealth services, and urgent care centers. • Assisting members as needed to locate participating providers and educating members about the importance of using participating providers. The Network Growth Report for MY 2022 indicates an increase of 279 providers.
2. The MCO maintains a provider directory that includes all requirements.	X					Policy MCD-21, Provider Directory, states that provider information used as the source for the online provider directory (Find a Doctor) is updated within 30 calendar days of receiving the new information, and that the online provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						data is refreshed daily to capture any updates. Printed directories are updated at least monthly. During review of the online Find a Doctor tool, non-functional links for FAQs and Conditions of Use were noted. *Recommendation: Correct the nonfunctional links to the FAQs and Conditions of Use on the Find a Doctor page of Healthy Blue's website.*
3. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
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 MCD-11, Medicaid Access and Availability, defines the appointment access standards to which network practitioners are expected to comply. Healthy Blue, through Symphony Performance Health (SPH) Analytics, an NCQA certified survey vendor, conducts an annual telephone survey to assess PCP and high volume (OB/GYN)/high impact (Oncology) specialist compliance with appointment access standards. Analysis of the results is conducted by QI and Provider Services staff and the Service Quality Improvement Committee (SQIC). Any identified problem areas are addressed with action plans.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2022 Quality Management Program Evaluation includes the results of the study conducted in 2022 and compares the results to the studies conducted in 2021 and 2020. The Program Evaluation included identified barriers, such as: • Lack of provider awareness of appointment access standards • Lack of member awareness of alternate options for urgent care other than PCPs • Lack of provider awareness of member expectations for what constitutes timely specialist appointments • Decreased staffing and increased workloads due to the Covid-19 pandemic Interventions to address the barriers include educating non-compliant providers about appointment access standards for urgent care, educating members on availability and use of telehealth and urgent care centers, and seeking contracts with new providers.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					For the Telephonic Provider Access Study conducted by CCME, Healthy Blue submitted a Provider File containing a population of 2,281 providers. A random sample of 161 PCPs was selected and attempts were made to contact these providers to ask a series of questions

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						regarding the access that members have with the providers. The calls were successfully answered 69.3% of the time (108 out of 156) when omitting five calls answered by voicemail messaging services. This is an improvement from last year's rate of 69%. For calls not answered successfully (n = 48 of 156 calls), the majority (n = 31, 64.5%) were because the provider was not at the office or phone number listed. Of 108 providers contacted, 98 (91%) confirmed that they accept Healthy Blue. Of the 98 that accept Healthy Blue, 57 (58%) are accepting new patients. For appointment availability, 42 of 57 (74%) did have availability for a routine appointment and 15 of 57 (26%) did not have routine appointment availability within contract requirements.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					Processes for provider orientation are found in Policy MCD-01, Education of Contracting Providers. Provider orientation is conducted by

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Network Management and/or Provider Education staff via onsite or virtual sessions at initial contracting and includes information about Healthy Blue and its programs, policies, procedures, Medicaid regulations, etc. A PowerPoint presentation used for provider orientation includes contact information for Provider Relations Representatives and other Healthy Blue departments, and information about provider roles and responsibilities, self-servicing functions of the provider website, member transportation, benefits information, the prior authorization look-up tool, claims, etc. The Provider Manual is comprehensive and includes information necessary for new and established providers to understand and navigate health plan operations and requirements. Healthy Blue's website "Provider education" page includes printable information about pertinent topics and provides links to the "My Diverse Patients" training website and the "CMS Toolkit - Telehealth for Providers: What You Need to Know" website. Providers may also register for the Provider Pathways eLearning

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						tool that "provides educational resources and trainings on behalf of BlueChoice HealthPlan."
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					The Provider Manual addresses member benefits but does not address BabyNet services or Rehabilitative Services for Children. *Recommendation: Revise the Provider Manual to include information about BabyNet services and Rehabilitative Services for Children.*
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					The Provider Manual includes comprehensive information about clinical practice and preventive health guidelines. Healthy Blue's website includes lists of all adopted clinical practice and preventive health guidelines with links to access complete information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Medical record handling, availability, retention and confidentiality;	X					The Provider Manual addresses general requirements for medical record maintenance, storage, and retention.
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					The Provider Manual refers the reader to the website to review the specific medical record documentation standards and provides information about the annual medical record audit process.
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing provider education includes Medicaid Managed Care policies and procedures, billing requirements, Fraud Waste Abuse, the False Claims Act, health plan policies and procedures, etc. Training is provided via virtual provider training sessions, provision of written materials and reference information, mailings, annual workshops, and routine provider contacts. Four regional provider trainings are provided annually and may be held virtually when on-site training is not an option.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					As noted in Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring – SC, Amerigroup approves preventive health guidelines (PHGs) on behalf of Healthy Blue. These guidelines are evidence-based and adopted from nationally recognized sources to educate providers about recommended preventive care services for members of various age groups. The Amerigroup Clinical Practice Guidelines/ Preventive Health Guidelines Workgroup reviews recommended changes to the PHGs annually and as needed. Membership of the workgroup includes Medical Directors and representatives from various departments, such as Care Management, Clinical Program Management, Disease Management, Provider Engagement & Contacting, etc. Once the guidelines are reviewed and approved, the recommendations are submitted to the health plan's Clinical Quality Improvement Committee (CQIC) for approval and adoption by the health plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Adopted guidelines are posted on Healthy Blue's website and information about the guidelines and how to view/obtain the guidelines is included in the Provider Manual. In addition, information about the guidelines is included in new provider orientation materials.
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 *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy SC_QMXX_048, Clinical Practice Guidelines - Review, Adoption and Distribution – SC, describes processes for adoption, review, and revision of clinical practice guidelines (CPGs) by Amerigroup on behalf of Healthy Blue. The CPGs include medical and behavioral health guidelines that are evidence-based and relevant to health plan membership. The purpose of the guidelines is to aid in decision-making about acute and chronic medical and behavioral health conditions. The guidelines are evidence-based and adopted from nationally recognized sources. CPGs are adopted following the process documented above for PHGs. Once the CPGs are approved, the recommendations are submitted to the health plan's CQIC for approval and adoption by the health plan. Once adopted, the CPGs are reviewed at least annually and updated as needed for changes to national guidelines.
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					Adopted guidelines are posted on Healthy Blue's website and information about the guidelines and how to view/obtain the guidelines is included in the Provider Manual. In addition,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						information about the guidelines is included in new provider orientation materials.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Healthy Blue promotes continuity and coordination of care between PCPs and other providers and facilities. PCPs are instructed that they are responsible for this coordination of care for their members. Compliance with the requirements for coordination of care is assessed primarily through medical record audits, and action is taken to address identified opportunities for improvement. An analysis of the effectiveness of the actions taken is conducted annually. Results are reported to the CQIC.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards – SC, describes processes the Amerigroup Clinical Quality Department conducts on behalf of Healthy Blue to evaluate provider compliance with medical record documentation standards. Healthy Blue's CQIC approves the medical record review standards. The Provider Manual refers providers to the website to review the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medical record documentation standards. CCME confirmed this information is available on the website.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
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 2022 Medical Record Compliance Audit was conducted on a sample of 109 records for 30 providers. The average score was 96.03 and no providers received a failing score. Results were reported to the CQIC in April 2023.
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 *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Information regarding member rights and responsibilities is included in the Healthy Blue Evidence of Coverage (Member Handbook), the Provider Manual, and Policy SC_ QMXX_104, Member Rights and Responsibilities.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					The New Member Materials Distribution policy contains detailed steps to ensure that new member packets are mailed to the member within 14 calendar days from the date the health plan receives enrollment data.
1.1 Benefits and services included and excluded in coverage;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						Services, associated costs, and resources for women are detailed in the Member Handbook and on the website.
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						The right to request a second opinion is described in the Member Handbook and website. Information about authorization requirements for both in and out-of-network providers is provided.
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;						The Benefits Quick Reference Guide details covered services, co-pay information, and authorization requirements specific to Healthy Blue benefits.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services and equipment requiring prior approval are outlined in the Benefit Quick Reference Guide located in the Member Handbook and on the website.
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;						Instructions for accessing 24-hour care are clearly outlined in the Member Handbook. Members are informed about the Nurse Advice Line as an additional resource. However, the PCP is emphasized as the first point of contact for assistance, with 911 to be used for life-threatening emergencies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 Policies and procedures for accessing specialty care;						Information about specialty providers is found in the Provider Directory. Processes and associated fees and authorization requirements are outlined in the Member Handbook.
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Information about obtaining prescription medications and durable medical equipment is outlined in the Member Handbook. Members are directed to the website to view the Preferred Drug List and to find participating pharmacies. Members may also contact Member Services to obtain this information.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
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;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						Instructions for accessing language assistance services and obtaining translations of member materials are outlined in the Member Handbook, and the website. Members may call the toll-free Customer Call Center or request information by email.
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						The New Member Packet – Contents policy describes the process for provision of member ID cards. Instructions for use are contained in the Member Handbook.
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;						Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are described in the Member Handbook, in the Benefits Quick Reference Guide, and on the website.
1.20 A description of advance directives, how to formulate an advance directive, and how to						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						Members who believe that fraud, waste, or abuse have been committed have a responsibility and a right to report it. Instructions for reporting options are listed in the Member Handbook, Provider Manual, and on the website.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Steps for enrollment and PCP selection are outlined in the Member Handbook and on the website.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Disenrollment information is located in the Member Handbook, on the website, and in policy SC_UMXX_125, Termination of Membership (Disenrollment) - Coordination of Care.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Healthy Blue contracts with Center for the Study of Services (CSS), a certified CAHPS survey vendor, to conduct the adult and child surveys.
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					The Quality Management Program Evaluation displayed analysis of data and action steps to achieve higher scores for member satisfaction.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Results were presented to the Quality Improvement Committee (QIC), and the committee initiated action plans to address problematic measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					

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					The CAHPS Outcome report was presented to the QIC.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy GAXX 015, Grievance Process: Members-SC, describes Healthy Blue's responsibility for the processing of grievances.
1.1 The definition of a grievance and who may file a grievance;	X					Grievances are appropriately and consistently defined in policy, the Member Handbook, Provider Manual, and website.
1.2 Procedures for filing and handling a grievance;	X					Members are informed that they may submit a grievance verbally or in writing at any time.
1.3 Timeliness guidelines for resolution of a grievance;	X					Acknowledgement letters are sent to members within five calendar days from the date of receipt. Grievances are resolved within ninety calendar days from the date of receipt. Extensions may be requested, if needed.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Grievance logs are retained for a minimum of 10 years in accordance with *S.C. Code Ann. § 38-33-110 (2) (a)* and the *SCDHHS Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO applies grievance policies and procedures as formulated.	X					Of the sample of grievance files selected for the 2023 EQR, timely standards for the acknowledgment, investigation, and resolution were met overall.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Amerigroup continuously reviews the grievance operation system to identify and report any emergent grievance patterns. Grievance analysis information is reported to Healthy Blue SQIC and Regulatory Compliance for oversight and follow-up.
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 *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Healthy Blue's 2023 Medicaid Quality Management Program Description describes Healthy Blue's primary goal as improving the quality and safety of clinical care and services provided to members through Healthy Blue's network of providers and its programs and services. Healthy Blue's President/Chief Operating Officer is the senior executive responsible for the Quality Improvement (QI) Program. The Board of Directors has authority, responsibility, and oversight of the Program and is responsible for the review and approval of the QI Program Description, work plan, and QI Program Evaluation. The Medical Director and Behavioral Health Medical Director provide clinical oversight. The QI Program Description mentions (page 13) "Annually, the Plan makes information about the QI program's progress against goals available to the members." Healthy Blue's website contained information regarding the QI Program; however, this information was from 2021 and therefore, outdated.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update the QI information on the Healthy Blue's website.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Over and underutilization of services data are monitored to help implement strategies to achieve utilization targets consistent with clinical and quality indicators. Utilization of services data are also used to identify potential fraud and abuse of services. Policy SC_UMXX_061, Under-and Over-Utilization of Services - Monitoring – SC, provides the process Healthy Blue follows for monitoring over and underutilization data.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Healthy Blue's QI Work Plan identifies specific activities and projects undertaken by the health plan. The 2022 and 2023 Work Plans were submitted for review. The work plans documented the planned activities, responsible parties, updates, and status for each activity.
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 CQIC and the SQIC support the administration of Healthy Blue's QI activities.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Membership includes internal and external health plan staff and external network providers. The internal staff include management from various areas. Voting members include seven actively participating network providers, who specialize in family medicine, OB/GYN, pediatrics, emergency medicine, and psychiatry.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The QI Committee meets at regular quarterly intervals.	X					The CQIC is authorized to meet as necessary, but no less than quarterly. A meeting quorum is met with the attendance of three network providers. The committee chair votes only in the case of a tie vote by the network providers.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes were provided for the CQIC meetings for meeting held in 2022 and the January and April 2023 meetings. It was noted that a quorum was not present for the July 20, 2022, and the April 16, 2023 meetings. For both meetings, documents requiring approval were sent to the voting members electronically for review and approval.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					The performance measure validation found that Healthy Blue was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*. Substantial changes in year over year trending were found in five measures, two measures with improvement and three measures with a decline. Influenza rates declined 45.99% to 35.52%, down 10.47%. Monitoring for people with cardiovascular disease and schizophrenia declined from 60% to 50%, and the imaging studies for low back pain rate declined 16.10%, from 70.77% to 54.67%. Improvement occurred for two metabolic monitoring rates for children and adolescents on antipsychotics. Rates

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						improved for cholesterol testing by 13.3% and for blood glucose and cholesterol testing by 12.59%.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					For the 2023 review, two PIPs were submitted and validated. The non-clinical PIP was CAHPS Customer Service, and the clinical PIP was Comprehensive Diabetes Care.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					Both PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Network providers are required by contract to participate and cooperate with any internal and external quality assessment reviews. Healthy Blue requires network providers to adhere to the QI Program requirements.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, Healthy Blue's QI department formally evaluated the QI program's overall effectiveness by analyzing outcomes from QI activities and data trends.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2022 Quality Management Program Evaluation was provided for review. This QI Program Evaluation included the results of the QI activities completed in 2022, a barrier analysis, any actions or interventions taken, and an assessment of the effectiveness of the interventions. The QI Program Evaluation was reviewed and approved by the CQIC in May 2023.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Healthy Blue's Utilization Management Program Description outlines the staff responsibilities, scope, and objectives for physical health and behavioral health services. The Pharmacy Program Description outlines the program objectives and standard operations of the pharmacy program.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					Healthy Blue's Utilization Management Program Description, Policy SC_UMXX _41, Preservice Authorization of Services-SC, and Policy SC_UMXX_082, Second Medical Opinion, outline the staff responsibilities, scope, and accountability for physical health and behavioral health services. The Director of Healthcare Management is responsible for ensuring best practices and quality service delivery of UM and Care Management services. Medical Directors provide clinical oversight of UM decisions, conduct Level II Reviews, and serve on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						various committees such as the Quality Improvement Council, Pharmacy Advisory, etc. The Pharmacy Director provides oversight of the pharmacy program and ensures program adherence to regulatory requirements. The Behavioral Health Medical Director provides oversight for the Behavioral Health UM Programs and is responsible for case consultations, development, and implementation of the behavioral health policies. UM review staff are licensed clinicians that conduct initial clinical reviews for authorization requests. Nonclinical staff provide support to the UM clinicians by assisting with outbound calls, developing a daily census report, and coordinate peer reviews as needed. Supervision for the UM clinicians and nonclinical staff is provided by the Healthcare Management Team Leaders that have several role responsibilities, such as queue management and consultations. Lastly, Medical Directors and licensed clinical staff are not involved in any decisions regarding a member they may be treating to ensure there is no partiality or bias in the review process, as identified in Policy GBD_UM_003, Conflict of Interest Policy.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 guidelines / standards to be used in making utilization management decisions;	X					Health Blue's UM Program Description and policies such as Policy SC_UMXX_041, Preservice Authorization of Services, Policy GBD_HCM_002,Clinical Criteria for Utilization Management Decisions, and Policy GBD_UM_026, Utilization Management Clinicians Responsibilities, describe the use of external and internal guidelines.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					Healthy Blue's Utilization Management Program Description states that the Medical Policy, Formation and Investigational Criteria Medical Policies address the evaluation of new and emerging technologies that may enhance patient care. The Office of Medical Policy & Technology Assessment is responsible for review and evaluation of the emerging technologies and develop recommendations for quality enhancement.
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Policy SC_UMXX_065, Separation of Financial and Medical Necessity Decision Making, identifies that UM reviews are conducted by licensed qualified professionals that are based upon appropriateness of care and is not promoted by any financial or cost saving incentives.
1.7 the mechanism to provide for a preferred provider program.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					UM Reviewers utilize evidenced based criteria such Milliman Clinical Guidelines (MCG), Medical Policies, Carelon Medical Benefits Guidelines State Guidelines, etc. to make clinical coverage decisions. The practitioners have access to clinical coverage criteria through the designated health plan portal as described in Healthy Blue's Utilization Management Program Description, Policy SC_UMXX_041, Preservice Authorization of Services, Policy GBD_HCM_002, Clinical Criteria for Utilization Management Decisions, and Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of the approval files showed that appropriate clinical criteria is applied in making clinical determinations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					As described in various policies and the Utilization Management Program Description, individual member circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. Review of the approval files reflected that individualized clinical needs are taken into consideration and clinical consultations occurred appropriately.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Healthy Blue utilizes several methods to measure consistency of clinical application and quality assurance in managing authorizations requests for clinical reviewers. Annually, Inter Rater Reliability testing is conducted to ensure consistency and accuracy of medical necessity criteria. Based upon the 2021 Inter Rater Reliability results, the UM Reviewers and Physicians received a passing score. Also, the Process Improvement Team ensures quality assurance through monthly focused review audits that entail analysis of a random sample of three to five cases to evaluate timeliness and consistency in clinical application, and to identify any trends or deficiencies. The feedback is provided to UM Leadership for training and support as needed. The findings are also presented to the SQIC for review. The departmental goal is 95% and based upon the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recent review, the department exceeded the targeted goal.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Medication changes are reviewed and approved by the Pharmacy and Therapeutics Committee. Formulary changes are updated quarterly on the website and members are notified 30 days prior to the negative formulary changes. Over-the-counter medications are covered for Healthy Blue members. Healthy Blue's pharmacy benefit manager, CarelonRx, is responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities as described in the Pharmacy Program Description. Onsite discussion revealed that CarelonRx changed their name from IngenioRx in January 2023. The Pharmacy Program Description continues to reflect IngenioRx as the pharmacy benefit manager, and the website identifies CarelonRx as the current pharmacy benefit manager. During onsite discussion, the health plan stated they are in the process of transitioning their documentation to the updated name change.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Update all documentation and communication to reflect the Pharmacy Benefit Manager's name change to CarelonRx.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Healthy Blue's process and guidelines for covering emergency and post stabilization services are outlined in Policy GBD HCM 005, Emergency Services-Core Process, Policy GBD UM 006, Coverage for Post Stabilization Care Services, and the UM Program Description.
8. Utilization management standards/criteria are available to providers.	X					Clinical criteria are available to members and providers upon request, as described in the Utilization Management Program Description.
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Approval files reflected that the approval decisions were promptly communicated to the provider and/or member.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
information prior to making the decision to deny services.						
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of the denial files confirmed that an appropriate physician specialist reviewed the adverse benefit determinations.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of the denial files demonstrated that the adverse benefit decisions were promptly communicated to the provider or member.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC_GAXX_051, Member Appeal Process (Physical Health), Policy SC_GAXX_053, Provider Appeal Process-SC, the Behavioral Health Member Appeals-Core Process Policy, the Behavioral Health State Fair Hearing Policy and Procedure, the Utilization Management Program Description, the Provider Manual, and the Member Handbook outline Healthy Blue's appeals process.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					Processes and requirements for filing an appeal are addressed in the policies and documents listed above.

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					Expedited appeals are addressed in the policies and documents listed above.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Resolution timeframes for appeals are addressed in various policies, the Utilization Management Program Description, Provider Manual, and Member Handbook. Policy SC_GAXX_051, Member Appeals process identified that if a standard appeal determination is not made within the established timeframes, the member's request would be approved. However, the policy does not address that expedited appeals will be considered approved if an appeal determination is not made within the established timeframes. *Recommendation: Consider adding in Policy SC_GAXX_051, Member Appeal Process, that an expedited appeal determination will be deemed approved if a determination is not made within the established timeframes.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				The review of a sample of appeal files revealed that the appeal files were processed in a timely manner according to contractual guidelines. However, three expedited files' acknowledgement letters and appeal extension letters provided incorrect timeframes for appeal resolution and extension. The acknowledgement letters indicated that the appeal will be processed in 30 days and the appeal extension timeframe was 44 days from date of appeal submission, which does not coincide with contractual requirements of 72 hours for expedited appeal resolution and a total of 17 days when an extension of an expedited appeals is implemented. *Quality Improvement Plan: Ensure acknowledgement and appeal extension letters communicate the correct timeline for resolution.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeal quarterly reports are presented during the SQIC, and trends and opportunities for improvement are discussed. A yearly summary of appeals is also provided in the Utilization Management Annual Evaluation and Quality Management Evaluation.

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 *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					Policy GBD_PHHS_201, Complex Case Management, Policy GBD_CM_102, Complex Case Management, Population Health Strategy, and the Complex Case Management Program Description provide a descriptive overview of Healthy Blue's Case Management and Care Coordination Program. The Population Health Workgroup is comprised of clinical and nonclinical staff that meets monthly. The objective of the workgroup is to conduct an analysis of the most prevalent diagnoses within the populations and develop strategies to promote disease management. Additionally, the Complex Care Management Program Description, page 11, includes a description of the Clinical Advisory Group as a composition of clinical and nonclinical leadership that meets quarterly and provides oversight. However, during onsite discussion, the health plan identified that there was not currently a Clinical Advisory Group. *Recommendation: Remove reference to the Clinical Advisory Group within the Complex Care Management Program Description, as this is*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						identified as not providing oversight of the care management program.
2. The MCO has processes to identify members who may benefit from care management.	X					Policy GBD_CM_102, Complex Case Management, and Policy SC_CAXX_007, Care Management Targeting/Case Finding, describe various referral sources, such as internal referrals, provider referrals, self-referrals, health information exchanges, predictive modeling etc. that aid in identifying potential members for case management services. Policy GBD_CM_102, Complex Case Management, referenced Policy GBD_CM_101, Member Identification and Assessment of Populations, as a policy reference on the member referrals process. However, during the onsite discussion, Healthy Blue reported that this policy is no longer active. *Recommendation: Remove reference to Policy GBD_CM_101, Member Identification and Assessment of Populations in Policy GBD-CM-102 Complex Case Management (Care Compass) as this policy is no longer active.*
3. The MCO provides care management activities based on the member's risk stratification.	X					
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					Policy SC_CAXX_108, Targeted Case Management Identification and Referral of Eligible Members, the Member Handbook, and the Complex Case Management Program Description provide an overview

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of the care management activities that are provided to members. Healthy Blue has developed several strategies such as conducting telephone follow-up calls during evening hours, developing community partnerships, providing education, and approved incentives to members to promote increased engagement in the care management program.
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					Behavioral Health and Physical Health Case Management Staff identify members that exhibit co-occurring behavioral health and medical needs. The team works collaboratively to ensure the total needs of the member are met through various strategies. such as co-management of cases, joint visits, and coordination of care efforts. Based upon the member's prevalent behavioral or medical needs, a primary care manager will provide care management to the member.
6. Care Transitions activities include all contractually required components.						
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					Healthy Blue's Health Case Managers serves as the Transition Coordinator to assist and provide coordination of care services for members with identified transition needs, as outlined in Policy GBD CM 110, Integration and Transition of Care (Care Compass).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					
8. Care management and coordination activities are conducted as required.	X					Healthy Blue's care management files indicated that care management activities are performed appropriately, including conducting care management assessments, treatment planning, follow-up, and linkage to appropriate community resources.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Utilization Management - Medicaid Delegation and Oversight policy and Policy MCD-10, Credentialing Delegation, address processes for evaluating potential delegates to determine their abilities to comply with contractual requirements and health plan standards prior to implementation of written delegation agreements. These documents also address requirements for annual oversight and ongoing monitoring of all approved delegates. Written delegation agreements are implemented with each approved delegate. These agreements specify delegate responsibilities, delegated activities, reporting requirements, consequences of non-compliant or sub-standard performance, etc. Healthy Blue has delegation agreements in place with the following entities: • CarelonRx • CaremarkPCS (CVS) • AnMed Health • HCA Physicians Services Group

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Medical University of South Carolina • Prisma Health • Roper St. Francis Physician's Network • Self Regional Healthcare • South Carolina Department of Mental Health • Spartanburg Health/Regional Health Plus • Tenet (HCS Physicians) • VSP Vision Care
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					Oversight documentation was submitted for the delegates conducting activities for Healthy Blue. The documentation confirmed annual oversight was timely. Any identified issues were documented and resulting corrective actions were identified, along with recommendations as appropriate. Audit tools for the various delegated functions were thorough and included all requirements.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring – SC, describes processes for evaluating provider compliance with preventive care recommendations. Healthy Blue monitors provider compliance with provision of recommended immunizations for all members. This monitoring is conducted primarily through the annual medical record audit. In addition, HEDIS gap-in-care data is monitored on a monthly basis.
1.2 performing EPSDTs/Well Care.	X					Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services – SC, includes information that providers are educated about the EPSDT Program and recommended immunizations. Compliance with provision of recommended EPSDT services is monitored through the annual medical record audit and by monitoring HEDIS gap-in-care data.

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