# 2021 External Quality Review

## ABSOLUTE TOTAL CARE

Submitted: February 24, 2022

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

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# EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (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 2021 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Absolute Total Care (ATC) since the 2020 Annual Review.

The goals and objectives of the review are to:

- Determine if ATC 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 2020 annual external quality review 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 included a desk review of documents, a two-day virtual onsite visit, a Telephonic Provider Access Study, compliance review, validation of performance improvement projects, validation of performance measures, and validation of 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, those requirements are:

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

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

To assess ATC'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*

Absolute Total Care has policies and procedures in place to ensure adherence to the *SCDHHS Contract* and federal regulations. Policies are reviewed annually and revised as needed. Sufficient staffing is in place to ensure that health care services required by SCDHHS are provided to members. Lines of responsibility and reporting are clearly delineated on ATC's 2021 Organizational Chart.

The 2021 Compliance Plan Matrix emphasizes ATC's Compliance and Ethics Program that addresses policies, procedures, and standards of conduct. ATC has adopted the standardized Business Ethics and Conduct policy of its parent company, Centene Corporation (Centene). The Business Ethics and Code of Conduct stipulates that ATC will be transparent and transact business in full compliance with the law and in accordance with the highest principles of business ethics and conduct. All employees are expected to comply with the standards of behavior and performance, and any noncompliance will be remedied.

The Compliance Officer is identified in the Organizational Chart. The South Carolina Market Compliance Committee Charter outlines the roles and responsibilities of the committee and its members. The Compliance Committee meets quarterly and as needed, and reports to the Board of Directors. Working in collaboration with the Compliance Officer, the committee provides oversight for, and guidance in, adopting and implementing an effective Compliance Program.

Compliance training and education is mandatory at the time of hire and annually. Fraud Waste and Abuse (FWA) reporting options are explained in Policy CC.COMP.03, Speaking Up: Reporting Concerns, Policy Violations, Misconduct and Non-Compliance. The employee handbook augments training and educates employees about the Federal False Claims Act. Policies and procedures are in place outlining the expectations of compliance with all applicable laws with respect to the use and disclosure of Protected Health

Information (PHI), Personally and Individually Identifiable Information, Confidential Health Care Provider Information, and Confidential Company Information.

### *Information Management System*

ATC's Information System Capabilities Assessment (ISCA) documentation indicates that the MCO is capable of meeting the requirements of the *SCDHHS Contract*. The organization's policies and procedures adhere to industry best practices and are reviewed regularly to ensure they are valid/applicable. ATC's system security plan notes that a monitoring system has been implemented that allows the company to verify that information systems are in compliance with federal, state, and contractual requirements. Recent disaster recovery tests demonstrate that ATC's information systems are able to be fully recovered from a serious disaster.

### *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*

Requirements and processes for initial credentialing and recredentialing are documented in policies and procedures, with state-specific requirements included in attachments and/or footnotes. Appropriate timeframes are followed for processing initial credentialing applications and recredentialing occurs every 36 months. According to the most recent Credentialing Committee minutes submitted for review, ATC's Credentialing Committee includes only one network practitioner with a specialty of Pediatrics. Other physician members are health plan employees with specialties of Anesthesiology, Surgery, and Psychiatry. CCME recommends that ATC recruit additional network physicians for the Credentialing Committee to ensure broad representation from all disciplines within the network.

ATC measures practitioner type and availability annually through Geo Access mapping and considers survey results and grievance data when assessing network adequacy. The Quality Assessment and Performance Improvement Program Evaluation Medicaid and Marketplace - 2020 states geographic access goals were met in 2020. ATC's Geo Access mapping dated November 10, 2021, did not include results for all providers designated by SCDHHS as Status 1 provider types. This is a repeat finding from the previous EQR.

ATC monitors member access to primary, behavioral health, and specialty care services annually. Policy CC.PRVR.48, Evaluation of the Accessibility of Services, does not define the appointment access standards followed but appointment access standards are found in the Member Handbook and Provider Manual. CCME recommends that the appointment access standards monitored for its South Carolina Medicaid network be included in a policy.

Processes are in place to ensure the provider network can meet the cultural, linguistic, and accessibility needs of its membership. ATC's Provider Manual includes a Cultural Competency Overview and informs providers of their responsibilities related to culturally competent care for members. ATC provides language assistance, including qualified interpreter services, video relay and TTY communication services, sign language services, bilingual staff, etc.

Initial provider orientation is conducted within 30 business days of a provider becoming active with ATC and regular, ongoing meetings are held with established network providers. Annual provider training sessions are held in at least four regional locations throughout the state. Provider training includes a range of topics, including the expectation that providers use the adopted preventive health and clinical practice guidelines and that compliance will be monitored through review of HEDIS measures and random medical record audits. The guidelines are distributed to providers through the ATC website, provider orientation materials, mailings, newsletters, and fax blasts.

Providers are also educated about required medical record documentation standards, and annual medical record documentation audits are conducted. Results are trended to determine opportunities for improvement, and results are considered at recredentialing. The Medicaid Medical Record Review 2021 Annual Audit Report indicates the overall score was 96.4%, an increase from the previous year's score of 95%.

As part of the annual EQR process for ATC, CCME conducted a provider access study focusing on primary care providers. The successful call rate was 61% (96 of 157) and is a statistically-significant decreased from the previous year's result of 73%.

### *Member Services*

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

Policies and procedures are in place that define how ATC advises members of their rights and responsibilities and how these rights are protected. Upon enrollment, members receive a Member Welcome Packet and Member Handbook detailing their rights and responsibilities. Information summarizing covered and not covered services, copayments, prior authorization requirements, and limits of coverage is provided in the Member Handbook and on the ATC website.

A nurse advice line is available for member health questions 24 hours a day, seven days a week. The Member Handbook, Provider Manual, and website define service levels and outline steps for accessing care for urgent and emergent needs. Within 15 days after receipt or issuance of a provider termination notice, written notification of termination of a contracted provider is provided to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

The member enrollment process is outlined in policy, the Member Handbook, and on ATC's website. Processes are in place to auto-assign members to a PCP if the member does not select a PCP at enrollment. New Member Welcome Letters are mailed within 10 days of receipt of the member listing file from SCDHHS's enrollment broker. Appropriate processes are in place for member-initiated disenrollment requests.

ATC contracts with SPH Analytics, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey vendor, to conduct child and adult surveys. The Quality Improvement Committee (QIC) minutes from August 2021 documented the CAHPS discussion of results and analysis. The Child survey response rate of 9.4% demonstrated a decline from the previous year's rate of 11.8%. The adult response rate of 12.1% represented a slight decline from the previous year's rate of 12.4%.

The 2021 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description describes processes to ensure that members, through the month of their 21st birthday, receive comprehensive and preventive health care and services based upon adopted practice guidelines.

Grievance files reviewed indicated staff follow appropriate processes for reviewing and resolving grievances. Timelines and required guidelines were met for the file sample reviewed the 2021 EQR.

### *Quality Improvement*

*42CFR §438.330, 42 CFR §457.1240 (b)*

ATC's Quality Improvement (QI) Program is designed to monitor, evaluate, and improve the quality of care and services provided to all members. The QI Program is managed at the health plan and no activities are delegated. The 2021 Quality Program Description – Medicaid/Marketplace was submitted for review. The scope of work described in the program description includes areas such as preventive health, acute and chronic care, over- and under-utilization, population health management, behavioral health, continuity and coordination of care, accessibility and availability of care, member services, patient safety, HEDIS and CAHPS results, provider satisfaction, and health outcomes. On an annual basis, the Quality Department reviews the Quality Program Description and makes revisions as needed. Annually, ATC makes information about its Quality Program available to members and practitioners. ATC's website contained several resources explaining the Quality Program and directions for calling with additional questions.

ATC develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. ATC presented the 2020 and 2021 QI Work Plans for review. Both were reviewed and updated at least quarterly. ATC also addressed previously identified issues and opportunities.

ATC's Quality Improvement Committee is the senior management committee accountable to the Board of Directors. The QIC provides oversight and direction in assessing the appropriateness of care and service delivery. The QIC is chaired by the Chief Medical Officer. Other members include senior management staff, network practitioners, and other support staff. Detailed records and minutes for all meetings are maintained. The committee minutes were complete, signed and dated by the recorder and the chair. Copies of the committee minutes provided by ATC demonstrated the committee met at quarterly intervals.

ATC offers a quality, cost, and utilization tool designed to support and identify provider performance opportunities and assist with population health management initiatives. ATC also offers a provider report card that focuses on pediatric measures. ATC did not send the provider report cards in 2021 due to the changes in the well child measures and true benchmarks not being available. Providers were notified of this change and rates were made available on ATC's website.

ATC evaluated the effectiveness of the QI program and activities conducted in 2020 and provided CCME with a copy of this formal evaluation. The 2020 Quality Program Evaluation included a summary and results for each quality activity, any barriers identified, and opportunities for improvement. The Delegated Vendor Oversight Section, page 43, was incomplete.

### *Performance Measure Validation*

CCME conducted a validation review of the HEDIS measures following 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 ATC 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 for the current review year (2021), as well as the previous year (2020) and the change from 2020 to 2021, are reported in the Quality Improvement section of this report.

The following table provides a summary of rates that had a substantial (>10%) change from last year to this year. There were five rates that had a substantial increase and eight rates that had a substantial decrease.

**Table 1: HEDIS Measures with Substantial Changes in Rates**

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | Change from 2020 to 2021 |
|---|---|---|---|
| **Substantial Increase in Rate (>10% improvement)** | | | |
| Follow-Up After Emergency Department Visit for Mental Illness (fum) | | | |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | Change from 2020 to 2021 |
|---|---|---|---|
| *6-17 years - 7-Day Follow-Up* | 44.07% | 55.56% | 11.49% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Opioid abuse or dependence: Initiation of AOD Treatment18+ Years* | 43.93% | 59.36% | 15.43% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 19.08% | 31.53% | 12.45% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: Total* | 43.95% | 59.46% | 15.51% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 19.19% | 31.45% | 12.26% |
| **Substantial Decrease in Rate (>10% decrease)** | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | | | |
| *BMI Percentile* | 87.59% | 73.48% | -14.11% |
| *Counseling for Nutrition* | 72.26% | 61.07% | -11.19% |
| *Counseling for Physical Activity* | 67.40% | 57.18% | -10.22% |
| Appropriate Testing for Pharyngitis (cwp) | | | |
| *65+ Years* | 70.59% | 50% | -20.59% |
| Asthma Medication Ratio (amr) | | | |
| *19-50 Years* | 60.16% | 49.66% | -10.50% |
| *51-64 Years* | 61.84% | 48.24% | -13.60% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | 79.37% | 68.89% | -10.48% |
| Comprehensive Diabetes Care (cdc) | | | |
| *Eye Exam (Retinal) Performed* | 57.85% | 47.2% | -10.65% |

## *Performance Improvement Project Validation*

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

For the current EQR, three PIPs were submitted. Topics include Postpartum Care, Provider Satisfaction, and Hospital Readmissions. The Postpartum Care PIP was retired and not included in this validation. The Provider Satisfaction and Hospital Readmission PIPs scored in the "High Confidence in Reported Results" range. The reported rates for both PIPs showed improvements in the rates and interventions were effective. A summary of each PIP's status and the interventions are included in the tables that follow.

**Table 2: Provider Satisfaction PIP**

| Provider Satisfaction | |
|---|---|
| The objective for the Provider Satisfaction is to identify opportunities and implement initiatives to positively impact provider satisfaction and meet or exceed the plan's goal of the 75th percentile as defined by the SPH Analytics Medicaid Book of Business. The 2018, 2019, and 2020 rates were included in the PIP report for Overall Satisfaction with Absolute Total Care showing a reduction from 73.4% in 2018 to 57.9% in 2019 which then improved to 68% in 2020. This is below the goal rate of 75th percentile for Book of Business. | |
| **Previous Validation Score** | **Current Validation Score** |
| 87/88=99%<br>High Confidence in Reported Results | 100/100=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Monthly roster updates and quarterly batch loads serves to mitigate provider abrasion with inaccurate enrollment data which causes claims payment inaccuracy.<br>• Workgroup meetings to review and expedite claims adjustments and claims reconsiderations.<br>• Robust training and orientation for Provider relations and Customer Service Representatives. Leads from other functional areas attend team meetings to present on their scope and processes to familiarize the staff on additional business functions.<br>• Provider education with quarterly virtual Town Hall meetings and developing and distributing educational materials on the provider portal and online tools to include how to access the formulary. | |

**Table 3: Hospital Readmissions PIP**

| Hospital Readmissions | |
|---|---|
| The health plan's overall rate for readmissions for the previous twelve months was 18.0% with several months during that period having a rate greater than 18.0%. After analysis of the data, ATC's department leaders and Quality Improvement Committee identified an opportunity for improvement in reducing readmissions and a PIP was approved. The goal set internally for this PIP is to reduce the readmission rate to 17.5%. Data were reported for the baseline and Remeasurement 1. The results show a decline in readmissions from 18% to 16.2% in the 2020/2021 measure. These results indicate improvement in reducing readmission and exceed the goal rate of 17.5%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 72/72=100%<br>High Confidence in Reported Results | 80/80= 100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • The Transition of Care (TOC) team assesses the members upon discharge and reviews the discharge summary, assists member with scheduling appointment within 7 days of discharge and forwards referrals for case management to ensure the member has the resources and services to prevent readmission. Quarterly meetings with managers and the TOC team to discuss the TOC process. | |

| Hospital Readmissions |
| --- |
| • Post Hospital Outreach (PHO) Team facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions<br>• Members with 10 or more medications, outreach is made to the PCP to reconcile medications, once all required information is obtained the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP.<br>• Members at risk for readmission based on most frequently admitted diagnosis are referred to Case Manager or to Intensive Care Coordination for outreach if not actively enrolled in case management.<br>• Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meet quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members.<br>• UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met. |

### *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)*

ATC has a comprehensive Utilization Management (UM) Program Description along with numerous policies and procedures that guide staff in the implementation of utilization management functions. The Chief Medical Director oversees all aspects of the UM Program. A Medical Director with a specialty in Psychiatry oversee activities related to behavioral health and a registered Pharmacist oversees the implementation, monitoring, and directing of pharmacy services.

The review of approval and denial decisions confirmed that ATC performs reviews using appropriate criteria with notification promptly communicated to the provider and member, as applicable. Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-rater Reliability testing. Recent results confirm scores above the 90 percent benchmark were obtained by all staff.

The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List (PDL) changes on ATC's website at least 30 days prior to implementation. ATC's Policy CC.PHAR.10, Preferred Drug List, includes this contract language; however, it lacked the process used to ensure these changes are published on the website. Also, notices for PDL changes were found on ATC's website; however, some of the PDL changes were not included on the website and/or the effective date for the changes were before the Pharmacy and Therapeutics (P&T) Committee met and approved the PDL changes. The PDL changes for 1st quarter 2021 only allowed a 20-day notice instead of the required 30-day notice.

UM denial files reflected timely decisions and notifications. The Adverse Benefit Determination letters were written in appropriate language for ease of member understanding, contained the rationale for the denial along with references to the criteria used, and supplied information on how to request an appeal. Overall, the denial decisions were made by an appropriate physician specialist. However, there were four cases that were questionable.

Policy SC.UM.13, Member Appeals, describes ATC's process for resolving member disputes and responding to member appeal requests. Information on the appeals process is also found in the Member Handbook and Provider Manual. ATC provided copies of the letter templates used for appeal requests. One letter template, provided to the member when ATC cannot process the appeal request, does not provide the member with their right to file a State Fair Hearing. The letter sent to members when an oral request for an appeal is made incorrectly mentions a written appeal request must be received following receipt of an oral appeal request.

Appeal files reflected acknowledgments and resolutions were completed timely. Policy SC.MM.13, Member Appeals, states "appeal decisions and requests to expedite an appeal decision will be made by a physician or other appropriate clinical peer of a same-or-similar specialty…" However, some of the appeal files reviewed did not meet this requirement. There were three files where the physician who made the appeal decision was not of the same or similar specialty.

ATC's 2021 Care Management Program Description and the Population Health Management Strategy Guide: 2021 provide information about the programs' purpose, scope, infrastructure, member identification, etc. Policies and procedures provide additional detail about Care Management (CM) processes and requirements. ATC's Care Management Program is based on evidence-based guidelines and uses the Case Management Society of America (CMSA) Standards of Practice for Case Management. CM staff are trained in person-centered thinking and motivational interviewing to guide member goal identification and actions. An integrated care management model is used, and members are assigned a single point of contact, such as a primary Care Manager, who is supported by a multidisciplinary Care Team.

ATC conducts an annual evaluation of the CM Program as well as annual surveys to provide an opportunity for members who have been enrolled in CM to give feedback about satisfaction with the program. The evaluation and recommendations are submitted to the QIC or other appropriate committee for review, action, and follow-up. The Population Health Management Impact Annual Report: 2020 indicates that for 2020, the goal satisfaction rate was met for all questions except one. Barriers and opportunities for improvement were identified, resulting in the plan implementing refresher trainings and

use of an enhanced Aunt Bertha platform to assist case management team in identifying community resources for members.

Overall, CM files reflected care management and coordination activities are conducted as required. For one file, the Complex Care Management Assessment indicated the member reported concerns with food insecurity in the previous 12 months; however, the assessment note indicated no economic and social conditions were identified. The care plan did include this as a barrier or concern and there was no documentation of referrals to support services or community resources.

### *Delegation*

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

Processes and requirements for delegation are thoroughly documented in policies. Prior to implementing a delegation agreement with a subcontractor, ATC evaluates the entity to ensure it can perform the delegated activities. For approved delegates, both parties sign a written document that serves as the delegation contract and defines performance expectations for both ATC and the delegate. Formal, annual evaluations are conducted to assess delegate performance and compliance to required standards. Ongoing monitoring is conducted via routine delegate reporting and meetings.

For several delegates, ATC did not submit annual oversight monitoring for 2021. The plan reported the evaluations will be completed in Q1 2022. For these delegates, the plan submitted evidence of quarterly meetings, daily output files, monthly activity reports, utilization detail and summary reports, and/or monthly and quarterly performance review reports. Annual oversight documentation for credentialing delegates reflected ATC evaluates the delegates' policies and procedures, committee minutes, ongoing monitoring results, and conducts credentialing and recredentialing file reviews. Documentation of the most recent annual evaluation confirmed ATC offers recommendations, implements corrective actions as needed for any identified deficiencies, and conducts follow-up to ensure the delegates address the findings.

### *State Mandated Services*

*42 CFR § Part 441, Subpart B*

ATC provides all core benefits required by the SCDHHS Contract.

ATC measures provider compliance with administering required immunizations and performing required EPSDT services through medical record compliance audits and HEDIS reporting measures. Interventions for improvement are initiated as needed. QI Outreach Teams conduct education and inform, track, and follow-up with members and providers to improve overall EPSDT screening rates and related HEDIS performance measures. PCPs receive monthly reports that identify EPSDT eligible members on their roster that are

new to ATC and have not had an EPSDT visit. Preventive and clinical guidelines are posted on ATC's website, listed in the Provider Manual, and are available in hard copy upon request.

The current EQR revealed a repeated finding from the previous EQR related to inclusion of all required SCDHHS-designated Status 1 providers in Geo Access mapping.

## Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there was one standard scored as "Partially Met" and one standard scored as "Not Met." Following the 2021 EQR, ATC submitted a Quality Improvement Plan to address the deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on April 27, 2021. The following is a high-level summary of those deficiencies:

- Geo Access reports conducted in December 2020 did not provide evidence that access was measured for all Status 1 Provider types. The mapping did not include General Surgery and Rehabilitative Behavioral Health.
- Deficiencies identified during the previous EQR related to failure to include all SCDHHS-designated Status 1 provider types in Geo Access mapping were not corrected.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plan for ensuring all Status 1 providers are included in Geo Access mapping was not implemented. Of note, this was the third consecutive year this issue was noted.

## Conclusions

Overall, ATC 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 ATC'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**

| Standards | Category | Total Number of Standards | Number of Standards Scored as "Met" | 2021 Overall Score |
|---|---|---|---|---|
| Provider Services, Section II. B. Adequacy of the Provider Network | • Availability of Services *(§ 438.206, § 457.1230)* and<br>• Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)* | 8 | 6 | 75% |

| Standards | Category | Total Number of Standards | Number of Standards Scored as "Met" | 2021 Overall Score |
|---|---|---|---|---|
| Utilization Management, Section V. D. – Care Management Section V. E. – Transitional Care Management | • Coordination and Continuity of Care *(§ 438.208, § 457.1230)* | 8 | 8 | 100% |
| Utilization Management, Section V. B. – Medical Necessity Determinations | • Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)* | 14 | 13 | 93% |
| Provider Services, Section II. A. – Credentialing and Recredentialing | • Provider Selection *(§ 438.214, § 457.1233)* | 39 | 39 | 100% |
| Administration, Section I. E. - Confidentiality | • Confidentiality *(§ 438.224)* | 1 | 1 | 100% |
| Member Services, Section III. G. – Grievances Utilization Management, Section V. C. - Appeals | • Grievance and Appeal Systems *(§ 438.228, § 457.1260)* | 20 | 20 | 100% |
| Delegation Section | • Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)* | 2 | 2 | 100% |
| Provider Services, Section II. D. – Primary and Secondary Preventive Health Guidelines Provider Services, Section II. E. – Clinical Practice Guidelines for Disease and Chronic Illness Management | • Practice Guidelines *(§ 438.236, § 457.1233)* | 11 | 11 | 100% |
| Administration, Section I. C. – Management Information Systems | • Health Information Systems *(§ 438.242, § 457.1233)* | 7 | 7 | 100% |

| Standards | Category | Total Number of Standards | Number of Standards Scored as "Met" | 2021 Overall Score |
|---|---|---|---|---|
| Quality Improvement Section | • Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240 )* | 14 | 14 | 100% |

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

As noted in the table above, ATC received scores of "Met" for six of eight standards regarding Availability of Services and Assurances of Adequate Capacity and Services. This is due to the findings that ATC did not include Pediatrics practitioners in the Geo Access mapping and that the provider telephone access study conducted by CCME continues to indicate provider contact information is outdated—the successful contact rate dropped from 73% last year to 61% this year. Also, one standard related to Coverage and Authorization of Services was scored as "Partially Met" because the process for ensuring negative PDL changes are published on the health plan's website at least 30 days prior to implementation as required by SCDHHS was also a noted deficiency.

*Table 5, Scoring Overview,* provides an overview of the scoring of the current annual review as compared to the findings of the 2020 review. For 2021, 210 out of 214 standards received a score of "Met." There were two standards scored as "Partially Met" and two standards related to provider access and corrections for a previously identified deficiency that received a "Not Met" score.

**Table 5: Scoring Overview**

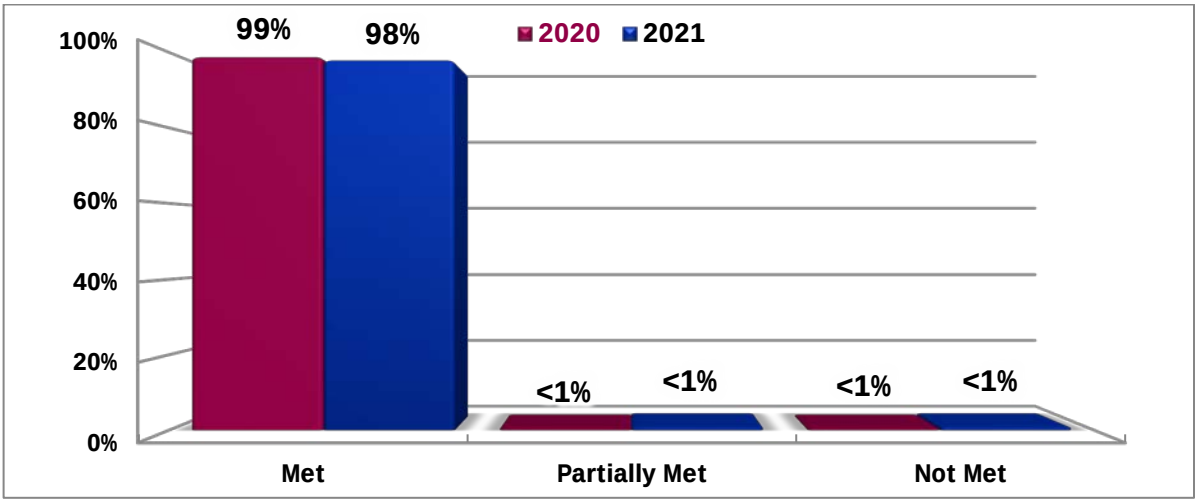
| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|---|
| Administration | | | | | | | |
| 2020 | 40 | 0 | 0 | 0 | 0 | 40 | 100% |
| 2021 | 40 | 0 | 0 | 0 | 0 | 40 | 100% |
| Provider Services | | | | | | | |
| 2020 | 75 | 1 | 0 | 0 | 0 | 76 | 99% |
| 2021 | 74 | 1 | 1 | 0 | 0 | 0 | 97% |
| Member Services | | | | | | | |
| 2020 | 33 | 0 | 0 | 0 | 0 | 33 | 100% |
| 2021 | 33 | 0 | 0 | 0 | 0 | 33 | 100% |
| Quality Improvement | | | | | | | |
| 2020 | 14 | 0 | 0 | 0 | 0 | 14 | 100% |
| 2021 | 14 | 0 | 0 | 0 | 0 | 14 | 100% |

| | Met | Partially Met | Not Met | Not Evaluated | Not Applicable | Total Standards | *Percentage Met Scores |
|---|---|---|---|---|---|---|---|
| Utilization | | | | | | | |
| 2020 | 45 | 0 | 0 | 0 | 0 | 45 | 100% |
| 2021 | 44 | 1 | 0 | 0 | 0 | 45 | 98% |
| Delegation | | | | | | | |
| 2020 | 2 | 0 | 0 | 0 | 0 | 2 | 100% |
| 2021 | 2 | 0 | 0 | 0 | 0 | 2 | 100% |
| State Mandated Services | | | | | | | |
| 2020 | 3 | 0 | 1 | 0 | 0 | 4 | 75% |
| 2021 | 3 | 0 | 1 | 0 | 0 | 4 | 75% |
| **Totals** | | | | | | | |
| 2020 | **212** | **1** | **1** | **0** | **0** | **214** | **99.07%** |
| 2021 | **210** | **2** | **2** | **0** | **0** | **214** | **98.13%** |

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

The 2021 Annual EQR shows that ATC achieved "Met" scores for 98.13% of the standards reviewed. As the following chart indicates, 0.93% of the standards were scored as "Partially Met," and 0.93% of the standards were scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2020 review results.

**Figure 1: Annual EQR Comparative Results**




*Scores were rounded to the nearest whole number*

## Assessment of Strengths and Weaknesses

The following is a summary of ATC'S strengths, weaknesses, and recommendations or opportunities for improvement related to the quality, timeliness, and access to care identified during this annual review.

**Table 6: Evaluation of Quality**

| Strengths Related to Quality |
|---|
| • Policies are well organized, clear in process, and reflect annual review.<br>• A review of ISCA document timestamps indicated the MCO frequently reviews and updates its documentation.<br>• Policy CC.COMP.16, Fraud, Waste and Abuse Plan, does a very good job of defining FWA and detailing education efforts, levels of investigation, and associated action.<br>• The MCO's business continuity and disaster recovery solutions are robust and tests indicate they perform as designed.<br>• Credentialing policies address all required credentialing and recredentialing elements, and credentialing files reflect staff, overall, follow appropriate processes for initial credentialing and recredentialing.<br>• ATC assesses the cultural, ethnic, racial, and linguistic needs of its membership and evaluates the ability of its provider network to meet members' needs annually. Adjustments are made as necessary to ensure the network is able meet the special needs of members.<br>• ATC continues to use alternate forums to ensure initial and continuing education for providers. The plan reports virtual education sessions are very successful and well-attended.<br>• Analysis of grievance type and/or patterns specific to providers or services are conducted and reviewed with appropriate committees in an effort to continue to improve member quality of care.<br>• ATC addresses any previously identified issues and opportunities for improvements in the QI work plan and in the QI program evaluation.<br>• ATC's HEDIS measures were compliant and met the validation requirements.<br>• The reported rates for the provider satisfaction and readmission performance improvement projects showed improvement in the rates and interventions were effective.<br>• The performance improvement projects scored within the "High Confidence Range" and met all validation requirements.<br>• Provider analytics offers a quality, cost, and utilization tool for providers to identify performance opportunities and assist with population health management. This tool prioritizes measures based on providers' performance to help identify where to focus clinical efforts.<br>• Consistent application of UM medical necessity criteria is monitored via Inter-rater Reliability testing. Recent results confirm scores above the 90 percent benchmark were obtained by all staff.<br>• Analysis of over- and under-utilization was comprehensive and demonstrates a focus on monitoring, evaluating, and addressing utilization issues.<br>• ATC's Care Management Program is based on evidence-based guidelines and uses the Case Management Society of America Standards of Practice for Case Management. The program follows the concepts, theory, and skills for Person Centered Practices as defined by Center for Medicare and Medicaid Services, National Quality Forum, and The Learning Community for Person Centered Practices. |

| Strengths Related to Quality |
|---|
| • Case Management staff are trained in person-centered thinking and motivational interviewing to guide member goal identification and actions.<br>• Processes and requirements for delegation are thoroughly documented in health plan policies. Prior to implementing a delegation agreement, ATC evaluates the entity to ensure it can perform the delegated activities.<br>• ATC measures provider compliance with administering required immunizations and performing required EPSDT services and initiates interventions for improvement as needed. QI Outreach Teams conduct education and inform, track, and follow-up with members and providers to improve overall EPSDT screening rates and related HEDIS performance measures. PCPs receive monthly reports that identify EPSDT eligible members on their roster that are new to ATC and have not had an EPSDT visit. |

| Weaknesses Related to Quality | Quality Improvement / Recommendations Related to Quality |
|---|---|
| • The ATC Credentialing Committee Roster for 2021 still includes a General Surgery provider who retired from the committee in February 2021 with no notation that the provider retired from committee membership. | • Recommendation: Ensure that the Credentialing Committee Roster is updated as members are added to or removed from the committee. |
| • The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, states MCO Credentialing Committees should have "broad representation from all disciplines (including mid-level practitioners)." ATC's credentialing committee includes only one network practitioner with a specialty of Pediatrics. Other physician members are health plan employees with specialties of Anesthesiology, Surgery, and Psychiatry. | • Recommendation: Recruit additional network physicians for the Credentialing Committee to ensure broad representation from all disciplines within the network. For example, recruit a Family Practitioner, OB/GYN, etc. and a mid-level practitioner, such as a nurse practitioner or physician assistant. |
| • One initial credentialing file was missing verification of the provider's National Provider Identifier. | • Recommendation: Ensure initial credentialing files for all providers include evidence of verification of the provider's National Provider Identifier. |
| • The ATC website includes the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide; however, the documents are listed under the heading of "Medicare-Medicaid Plan (MMP) Education and Training" on the "Provider Training" page and there is no heading for Medicaid Education and Training. | • Recommendation: Include the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide in an area of the website specific to Medicaid providers or move them to a general provider education section. |
| • ATCs Member Satisfaction Survey response rates have decline over the past three survey cycles. | • Recommendation: Continue conducting a barriers analysis to determine the issues with obtaining survey responses as response rates have decline over the past three survey cycles. |
| • The Delegation activities listed on page 26 of the 2021 QI work plan did not include oversight for all delegated entities. | • Recommendation: Include the oversight monitoring of all functions performed by a delegated entity in the QI work plan. |
| • The Delegated Vendor Oversight section (page 43) of the 2020 QI program evaluation appeared incomplete. The oversight for Envolve Benefit Options, Envolve People Care, and Envolve Pharmacy Solutions was not included in the | • Recommendation: Include the results of the oversight monitoring of all functions performed by a delegated entity in the QI program evaluation. |

| Weaknesses Related to Quality | Quality Improvement / Recommendations Related to Quality |
|---|---|
| results. Also, only the credentialing oversight for NIA was reported. | |
| • The decision to deny the services for four denial files were made by an inappropriate physician specialist. | • Recommendation: Re-educate physician reviewers regarding the option to consult with other physician specialties within Centene and through Advance Medical Review when making denial decisions outside of their expertise. Also, document this consultation in the file. |
| • One letter template used for appeal requests was missing the member's right to request a State Fair Hearing and another letter template incorrectly mentions a written appeal request must be received following receipt of an oral appeal request. | • Recommendation: Review and update the appeal letter templates to ensure the letter includes the member's right to fila a State Fair Hearing. Also, remove any references that require a member to submit the appeal in writing following an oral request. |
| • The physicians who made the appeal decision for three files did not have the appropriate clinical expertise (same or similar specialty) in treating the members' condition. | • Recommendation: For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician. |
| • Information about Targeted Case Management Services was not found in any of the Care Management policies. | • Recommendation: Include information about Targeted Case Management Services in an appropriate CM policy or program description. |
| • For one Care Management file, the Complex Care Management Assessment indicated the member reported concerns about food availability/money for food in the past 12 months. However, the related assessment note (page 12) states, "No economic and social conditions (SDOH) have been identified for member at this time that may impact ability to meet health care and case management goals." The care plan does not include this as a barrier or concern and there is no documentation of referrals to support services or community resources. | • Recommendation: Ensure that CM files include evidence that social determinants are identified, and referrals are made to appropriate support services or community resources, as stated in Policy CC.CM.02, Care Coordination/Care Management Services. |
| • During the previous EQR, Geo Access mapping reports did not include all required Status 1 provider types. In the current EQR, it was again noted that the Geo Access mapping reports did not include all required Status 1 provider types. | • Quality Improvement Plan: Ensure corrections for all deficiencies identified in the EQR are addressed and fully implemented. |

**Table 7: Evaluation of Timeliness**

| Strengths Related to Timeliness |
|---|
| • Grievance files demonstrated timelines of review and resolution. |
| • Utilization management decisions were timely, and members were notified of these decisions appropriately. |
| • Utilization Management files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination. |

| Weaknesses Related to Timeliness | Quality Improvement / Recommendations Related to Timeliness |
|---|---|
| • Policy SC.QI.08, Clinical and Preventive Practice Guidelines, the Provider Manual, and the QI Program Description indicate the guidelines are reviewed every two years. However, the QIC minutes for March 30, 2021, indicate the guidelines are reviewed at least annually. | • Recommendation: Revise Policy SC.QI.08, the Provider Manual, and the QI Program Description to state clinical practice guidelines are reviewed annually. |
| • The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List changes on the website at least 30 days prior to implementation. Policy CC.PHAR.10, Preferred Drug List, includes this contract requirement. The policy lacks the process used to ensure these changes are published on the website. Notices for PDL changes were found on ATC's website; however, some of the issues identified with this notification included:<br>o The Pharmacy and Therapeutics Committee met and approved the PDL changes after the effective date of the change. For example, 2nd quarter 2020 changes had an effective date of March 1, 2020. The changes were discussed at the P&T Committee meeting held on March 7, 2020.<br>o 1st quarter 2021 changes had an effective date of February 1, 2021. These changes were discussed at the P&T Committee meeting on January 12, 2021, which only gave a 20-day notice. Also, there were PDL changes discussed during the meeting and not included on the website notice.<br>o Several changes noted in the 1st quarter 2021 P&T Committee meeting minutes (meeting date January 12, 2021) had an effective date of December 1, 2020; however, no notice was found on the website (Procysbi and Rukobia). Semglee was discussed during the January 12, 2021 P&T meeting and posted on the website; however, the effective date was January 1, 2021 which was before the committee met. | • Quality Improvement Plan: Address in a policy or desk procedure the process for ensuring negative PDL changes are published on the website at least 30 days prior to implementation as required by *SCDHHS Contract, Section 4.2.21.2.3*. Ensure members and their prescribing practitioners are notified at least 30 days in advance of negative PDL changes via the health plan website. Consider including the date the notices are published on the website. |
| • Annual oversight monitoring for several delegates is untimely. | • Recommendation: Complete annual delegation oversight monitoring in a timely manner. |

**Table 8: Evaluation of Access to Care**

| Strengths Related to Access to Care |
|---|
| • Appropriate parameters are used to measure geographic access to providers within the ATC network.<br>• The online provider directory includes all required elements to allow members adequate information to select providers.<br>• Within 14 days of enrollment, members receive a Member Welcome Packet, Welcome Call, and Member Handbook detailing their rights, and responsibilities, and access to services. |

| Weaknesses Related to Access to Care | Quality Improvement / Recommendations Related to Access to Care |
|---|---|
| • The Geo Access mapping dated November 10, 2021, did not include results for all Status 1 provider types. This is a repeat finding from the previous EQR. | • Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all Status 1 providers. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2*. |
| • Policy CC.PRVR.19, Provider Directory – Portico, lists elements that must be included in the Provider Directory; however, the policy does not specify "age groups," as required by the *SCDHHS Contract, Section 3.13.5.1.1*. | • Recommendation: Update CC.PRVR.19, Provider Directory – Portico, to indicate "age groups" is a required element of the Provider Directory. |
| • Policy CC.PRVR.48, Evaluation of the Accessibility of Services, does not define the specific appointment access standards followed. | • Recommendation: Update Policy CC.PRVR.48, Evaluation of the Accessibility of Services, to include an attachment with the South Carolina Medicaid appointment access standards or create a South Carolina-specific policy to include this information. |
| • For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time (96 out of 157) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 73%, this year's study had a decrease in successful calls at 61% (p=.0257). This year's study had a decrease of 12%; it was statistically significant. | • Quality Improvement Plan: Determine additional methods to maintain updated information, such as current provider practice locations, in provider files. Increase E-Verify usage to more than four times per year to increase accuracy of provider files. |

# METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for the external quality review 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 November 29, 2021, CCME sent notification to ATC 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 ATC 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 ATC on December 13, 2021 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 conducted on January 26, 2022, and January 27, 2022. 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 ATC 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 ATC 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*

Absolute Total Care has policies and procedures in place to ensure adherence to the *SCDHHS Contract* and federal regulations. Policy CC.COMP.22, Policy Management,

provides guidance for the development, review, approval, and maintenance of policies. Policies are reviewed and approved on an annual basis and as needed.

The ATC 2021 Organizational Chart outlines the lines of business management and departmental oversight. Leadership positions were noted and it appears that sufficient staffing is in place to carry out all health care services required by the State of South Carolina.

The ATC Fraud, Waste and Abuse Plan and the 2021 Compliance Plan Matrix outline a training plan to educate employees, subcontractors, and/or providers about their role in the fraud, waste, and abuse (FWA) process; systematic methods to identify, prevent, review, and take corrective action against any provider or member who is suspected of participating in FWA activities; ways to calculate potential overpayments identified as a result of the reviews conducted; and ways to report identified issues to the health plan representative and federal/state agencies.

Compliance training and education process are addressed in Policy CC.COMP.10, Annual Compliance Training. The Compliance Department educates employees on federal and state laws and regulations annually through the following computer-based trainings: Privacy and Confidentiality, Administrative Firewalls, Fraud, Waste, and Abuse, Conflict of Interest and Gifts, and General Compliance and Code of Conduct. Reporting options are explained in Policy CC.COMP.03, Speaking Up: Reporting Concerns, Policy Violations, Misconduct and Non-Compliance.

The Business Ethics and Code of Conduct stipulates that ATC adopts a general policy of transparency, conducts business in full compliance with applicable laws and regulations, and in accordance with the highest principles of business ethics and conduct. All employees, as a condition of their employment, are asked to complete and sign a questionnaire acknowledging receipt and understanding of the Code of Conduct upon hire and annually. All employees are expected to comply with the Company's standards of behavior and performance, and ATC reserves the right to apply disciplinary action as appropriate to the outcomes of investigative findings.

The Compliance Officer is identified in the Organizational Chart. The South Carolina Market Compliance Committee Charter outlines the roles and responsibilities of the committee and its members. The Compliance Committee meets quarterly and as needed, and reports to the Board of Directors. Working in collaboration with the Compliance Officer, the committee provides oversight for, and guidance in, adopting and implementing an effective Compliance Program.

Policy CC.COMP. PRVC.04, Assurances from Business Associates to Safeguard Protected Health Information, outlines the expectations of compliance with all applicable laws with respect to uses and disclosures of Protected Health Information (PHI), Personally and

Individually Identifiable Information, Confidential Health Care Provider Information, and Confidential Company Information.

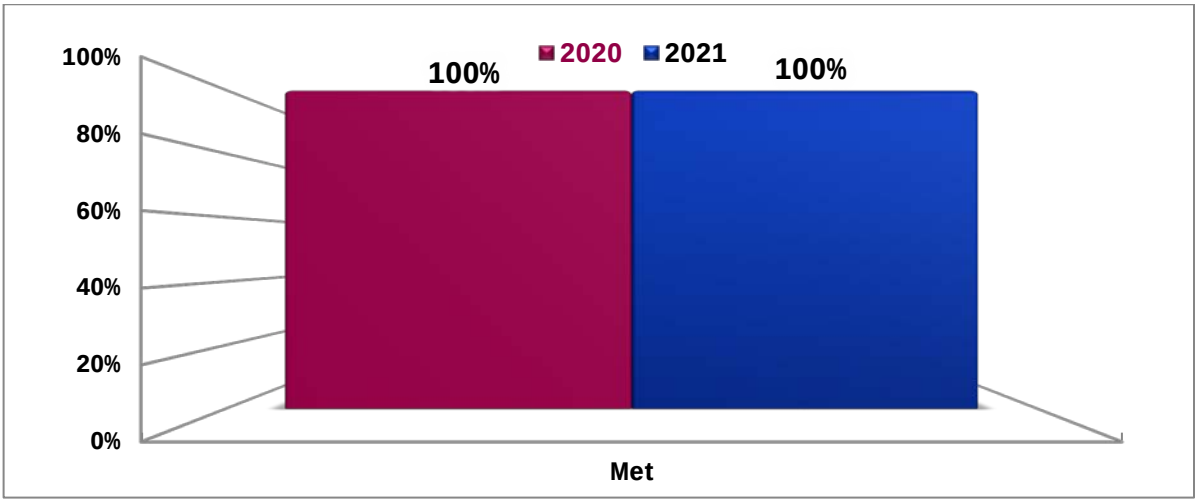
### *Information System Management*

42 CFR § 438.242, § 457.1233

ATC's Information Systems Capabilities Assessment (ISCA) documentation indicates the MCO is capable of meeting the requirements of the *SCDHHS Contract*. The organization's policies and procedures adhere to industry best practices and are reviewed regularly to ensure they are valid/applicable. ATC's system security plan notes that a monitoring system, which allows ATC to verify that information systems are in compliance with federal, state, and contractual requirements, has been implemented. Recent disaster recovery tests demonstrate that ATC's information systems are able to be fully recovered from a serious disaster.

As noted in *Figure 2: Administration Findings*, all standards for the Administration section of the 2021 EQR were scored as "Met."

**Figure 2: Administration Findings**




### *Strengths*

- Policies are well organized, clear in process, and reflect annual review.
- A review of ISCA document timestamps indicated the MCO frequently reviews and updates its documentation.
- The MCO's business continuity and disaster recovery solutions are robust and tests indicate they perform as designed.
- Policy CC.COMP.16, Fraud, Waste and Abuse Plan, does a very good job of defining FWA and detailing education efforts, levels of investigation, and associated action.

## 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, network adequacy and provider accessibility, provider education, clinical and preventive practice guidelines, practitioner medical records, and continuity of care.

### *Provider Credentialing and Selection*

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

Requirements and processes for initial credentialing and recredentialing are found in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and Policy CC.CRED.09, Organizational Assessment. Where applicable, state-specific requirements are included in attachments and/or footnotes. ATC processes credentialing applications in a non-discriminatory manner within 60 calendar days from receipt of a complete application, and providers are recredentialed on a 36-month cycle. The Medical Director can approve files for which there are no identified issues, and files that do not meet "clean file" criteria are taken before the Credentialing Committee for review and determination.

Policy CC.CRED.03, Credentialing Committee, describes the structure and functions of the Credentialing Committee. Voting members of the committee include the Medical Director and network physician attendees, and the quorum is defined as the presence of two-thirds of the voting members. The committee meets monthly and reports to the QIC. The policy does not address the attendance expectations for committee members, but the 2021 Quality Program Description-Medicaid/Marketplace defines the attendance expectation as at least 50% of the meetings.

According to the most recent Credentialing Committee minutes reviewed, ATC's Credentialing Committee includes only one network practitioner with a specialty of Pediatrics. Other physician members are health plan employees with specialties of Anesthesiology, Surgery, and Psychiatry. Because the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8* requires MCO Credentialing Committees to have "broad representation from all disciplines (including mid-level practitioners)," during the previous EQR, CCME recommended that ATC recruit an additional adult medicine provider for committee membership. ATC reported that very recently the Credentialing Committees for ATC and WellCare were merged, adding an additional adult PCP provider to the committee's membership. CCME continues to recommend that ATC recruit additional network physicians for the Credentialing Committee to ensure broad representation from all disciplines within the network.

CCME reviewed a sample of credentialing and recredentialing files for individual practitioners and organizational providers. The files reflected that staff, overall, follow appropriate processes for credentialing and recredentialing. Only one file was noted to have an issue—it was missing verification of the provider's National Provider Identifier.

### *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)*

Geographic access (time and distance) standards for primary care providers (PCPs) and specialists are documented in Policy CC.PRVR.47, Evaluation of Practitioner Availability. To evaluate the adequacy of its provider network, ATC measures practitioner type and availability annually through Geo Access mapping and considers survey results and grievance data regarding satisfaction with practitioner availability. Results are reviewed by the Quality Committee, which makes recommendations to address any identified deficiencies. The Quality Assessment and Performance Improvement Program Evaluation Medicaid and Marketplace - 2020 states geographic access goals were met for all PCP types as well as for high-volume and high-impact specialists in 2020.

A review of ATC's Geo Access mapping dated November 10, 2021, did not include results for all provider types designated as Status 1 providers in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* This is a repeat finding from the previous EQR. This finding was discussed with ATC staff during the onsite, and additional information was provided that "when GEO Access Reports were generated, Pediatrics was inadvertently omitted from the report." See *Table 9: Previous Adequacy of the Provider Network QIP Items*, for the previous EQR findings and ATC's response.

**Table 9: Previous Adequacy of the Provider Network QIP Items**

| Standard | EQR Comments |
|---|---|
| **II B. Adequacy of the Provider Network** | |
| 1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually. | The 2020 Medicaid QI Work Plan indicates Geo Access reports are run semi-annually, and onsite discussion confirmed network reporting is provided to SCDHHS twice yearly.<br><br>The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2* requires MCOs to have executed contracts with all Status 1 Providers. Additionally, the *SCDHHS Contract, Section 6.3,* requires the MCO to submit its provider network to SCDHHS "in accordance with this contract and as detailed in the Managed Care Policy and Procedure Guide" and to ensure "the submission reflects the CONTRACTOR's entire Provider network." |

| Standard | EQR Comments |
|---|---|
| | However, the Geo Access reports (dated December 21, 2020) submitted with ATC's desk materials did not provide evidence that access was measured for the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. Additional documentation (Geo Access mapping) was provided showing measurement of General Surgery and Rehabilitative Behavioral Health providers, but the date of the mapping was 2/26/21, after completion of the onsite.<br><br>*Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all Status 1 providers. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* |
| **ATC Response:** ATC has ensured when performing its evaluation of the Network Adequacy to evaluate and measure access to all Status 1 providers as required and defined in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2. | |

In addition to evaluating geographic access to network providers, ATC conducts annual assessments to determine the cultural, linguistic, and accessibility needs of its membership and to evaluate the ability of its provider network to meet those needs. Interventions are implemented as necessary and may include recruiting practitioners who speak alternate languages and with diverse cultural or ethnic backgrounds.

ATC's Provider Manual includes a Cultural Competency Overview and informs providers of their responsibilities related to culturally competent care for members. Providers are directed to the plan website or to contact Provider Services for more information. The ATC website includes the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide; however, the documents are listed under the heading of "Medicare-Medicaid Plan (MMP) Education and Training" on the "Provider Training" page and there is no heading for Medicaid Education and Training. ATC provides language assistance, including qualified interpreter services, video relay and TTY communication services, sign language services, bilingual staff, etc.

ATC monitors member access to primary care, behavioral health, and specialty care services annually, as described in Policy CC.PRVR.48, Evaluation of the Accessibility of Services. The policy does not define the specific appointment access standards followed but states information regarding appointment access and waiting time standards is found in the Member Handbook and Provider Manual. CCME recommends that the appointment

access standards monitored for the South Carolina Medicaid network be included in the policy or in an attachment to the policy. Data used in the monitoring include appointment access call studies as well as Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results and member grievances and appeals related to provider access. Results are analyzed by the Quality Committee and recommendations are made to address deficiencies. The most recent SC Appointment Audit was conducted in June 2021.

### *Provider Education*

*42 CFR § 438.414, 42 CFR § 457.1260*

Appropriate processes are in place for initial provider orientation and ongoing provider education. Initial orientation is conducted within 30 business days of a provider becoming active with ATC and regular, ongoing meetings are held with established network providers. In addition, annual provider training sessions are held in at least four regional locations throughout the state. ATC reported that, due to the Covid-19 pandemic, all provider education activities continue to be conducted virtually and have been well-attended.

ATC adopts preventive health and clinical practice guidelines from recognized sources and distributes the guidelines to providers through the ATC website, provider orientation materials, mailings, newsletters, and fax blasts. The Provider Manual includes a list of adopted guidelines and directs the reader to the website to review the guidelines. Providers may also request printed copies by contacting the health plan. Providers are informed that they are encouraged to use the guidelines and that ATC measures compliance through monitoring of HEDIS measures and random medical record audits.

ATC conducts annual medical record documentation audits for selected PCPs and may include high volume specialists. Results are trended to determine opportunities for improvement, and issues may be addressed via network-wide and/or provider-specific education. Results are shared with the Credentialing Department for consideration at recredentialing. The medical record documentation standards are found in Attachment A of Policy SC.QI.13, Medical Record Review, on ATC's website, and in the Provider Manual. The Medicaid Medical Record Review 2021 Annual Audit Report indicates all audited providers received passing scores. The overall score (96.4%) demonstrated an increase over the previous year's score of 95%.

### *Provider Access and Availability Study*

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

As part of the annual EQR process for ATC, CCME conducted a provider access study focusing on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,268 unique PCPs was identified. A sample of 178 providers

was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have to the contracted providers.

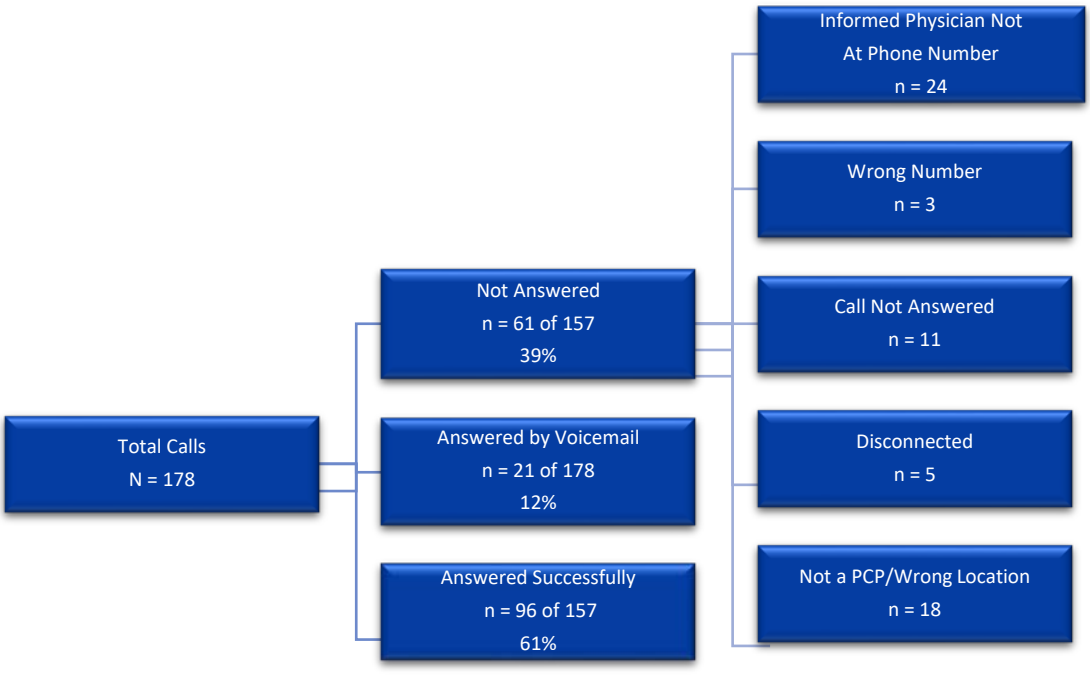
Calls were successfully answered 61% of the time (96 of 157) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's result of 73%, this year's study had a statistically significant decrease in successful calls at 61% (p=.0257), as shown in *Table 10: Telephonic Access Study Answer Rate Comparison*.

**Table 10: Telephonic Access Study Answer Rate Comparison**

| Review Year | Sample Size | Answer Rate | p-value |
|---|---|---|---|
| 2020 Review | 184 | 73% | .0257 |
| 2021 Review | 178 | 61% | |

*Figure 3: Telephonic Provider Access Study Results* provides an overview of the findings of the Telephonic Provider Access Study.

**Figure 3: Telephonic Provider Access Study Results**

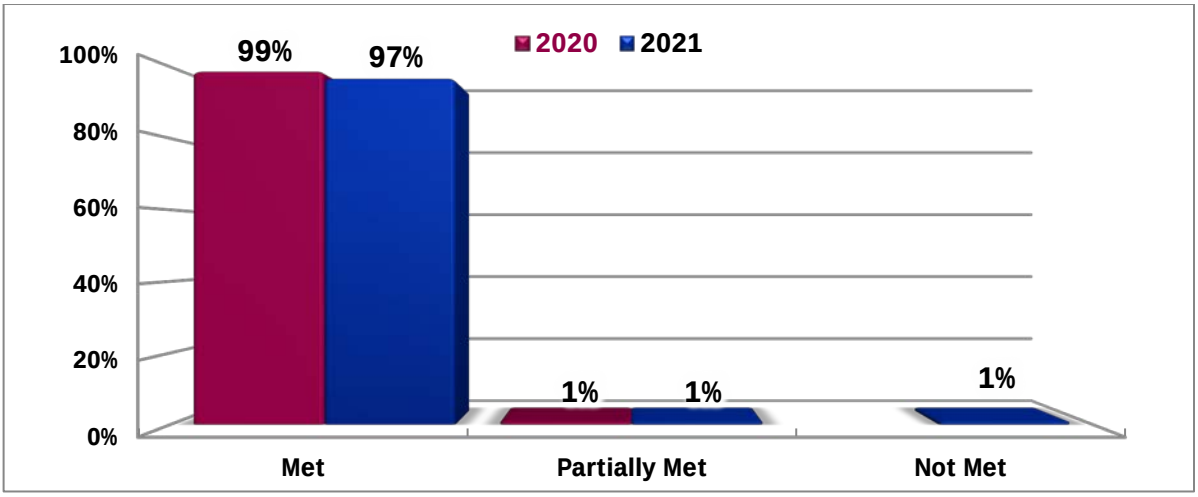



For the 61 calls not answered successfully, 24 (39%) were because the provider was no longer an active PCP at the location.

For the question "Do you accept Absolute Total Care?" 84 of 96 providers (88%) confirmed they accept ATC. Of those 84, 59 providers (70%) indicated they were accepting new Medicaid patients; and 45 of the 59 (76%) indicated they do not have prescreening requirements. Of the 14 providers with prescreening requirements, five (36%) required an application, seven (50%) required a medical record review, one (7%) required both, and one (7%) required vaccine records.

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 | 2020 REVIEW | 2021 REVIEW |
|---|---|---|---|
| Adequacy of the Provider Network | The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results. | Met | Not Met |

*The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.*

### *Strengths*

- Credentialing policies address all required credentialing and recredentialing elements. Credentialing files reflect staff, overall, follow appropriate processes for initial credentialing and recredentialing.
- Appropriate parameters are used to measure geographic access to providers within the ATC network.

- ATC assesses the cultural, ethnic, racial, and linguistic needs of its membership and evaluates the ability of its provider network to meet members' needs annually. Adjustments are made as necessary to ensure the network is able meet the special needs of members.
- The online provider directory includes all required elements to allow members adequate information to select providers.
- ATC continues to use alternate forums to ensure initial and continuing education for providers. The plan reports virtual education sessions are very successful and well-attended.

### *Weaknesses*

- The ATC Credentialing Committee Roster submitted for review includes a general surgery provider who retired from the committee in February 2021 with no notation that the provider retired from committee membership.
- The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, states MCO Credentialing Committees should have "broad representation from all disciplines (including mid-level practitioners)." ATC's credentialing committee includes only one practitioner (Pediatrics) who is not a health plan employee. Other physician members are health plan employees with specialties of Anesthesiology, Surgery, and Psychiatry.
- One initial credentialing file was missing verification of the provider's National Provider Identifier.
- The Geo Access mapping dated November 10, 2021, did not include results for all Status 1 provider types. This is a repeat finding from the previous EQR.
- The ATC website includes the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide; however, the documents are listed under the heading of "Medicare-Medicaid Plan (MMP) Education and Training" on the "Provider Training" page and there is no heading for Medicaid Education and Training.
- Policy CC.PRVR.19, Provider Directory – Portico, lists elements that must be included in the Provider Directory; however, the policy does not specify "age groups," as required by the *SCDHHS Contract, Section 3.13.5.1.1*.
- Policy CC.PRVR.48, Evaluation of the Accessibility of Services, does not define the specific appointment access standards followed.
- For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time. This is a statistically significant decrease of 12% from the previous year's successful call rate.

- Policy SC.QI.08, Clinical and Preventive Practice Guidelines, the Provider Manual, and the QI Program Description indicate the guidelines are reviewed every two years. The QIC minutes for March 30, 2021, indicate the guidelines are reviewed at least annually.

### *Quality Improvement Plans*

- Ensure evaluation of network adequacy includes measuring access for all Status 1 providers. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2*.
- Determine additional methods to maintain updated information, such as current provider practice locations, in provider files. Increase E-Verify usage to more than four times per year to increase accuracy of provider files.

### *Recommendations*

- Ensure the Credentialing Committee Roster is updated as members are added to or removed from the committee.
- Recruit additional network physicians for the Credentialing Committee to ensure broad representation from all disciplines within the network. For example, recruit a Family Practitioner, OB/GYN, etc. and a mid-level practitioner, such as a nurse practitioner or physician assistant.
- Ensure initial credentialing files for all providers include evidence of verification of the National Provider Identifier.
- Include the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide in an area of the website specific to Medicaid providers or move them to a general provider education section.
- Update CC.PRVR.19, Provider Directory – Portico, to indicate “age groups” is a required element of the Provider Directory.
- Update Policy CC.PRVR.48, Evaluation of the Accessibility of Services, to include an attachment with the South Carolina Medicaid appointment access standards or create a South Carolina-specific policy to include this information.
- Revise Policy SC.QI.08, the Provider Manual, and the QI Program Description to state clinical practice guidelines are reviewed annually.

## 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*

Policy SC.MBRS.25, Member Rights and Responsibilities, defines how ATC advises members of their rights and responsibilities and how these rights are protected. Upon

enrollment, members receive a Welcome Packet detailing their rights and responsibilities. The Member Handbook and website also contain and describe member rights and responsibilities.

The Member Handbook summarizes covered and non-covered services for members. Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual. Prior approval is not required for family planning services, emergency visits, or behavioral health services.

A Nurse Advice Line is available for member health questions 24 hours a day, seven days a week. Medical advice for children and adults, health information, assistance in determining where to go for care, answers to personal health questions, and information about pregnancy are topics available by calling the nurse advice line. The Member Handbook, Provider Manual, and website define service levels and outline steps for accessing care for urgent and emergent needs.

Written notice of termination of a contracted provider is provided to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. This notice is provided at least 30 calendar days prior to the effective date of the termination or within 15 days after receipt or issuance of the termination notice. Members are also notified of changes in benefits at least 30 days prior to the effective date of the change.

Information on member disenrollment is provided in policy SC.ELIG.10, Member Disenrollment, the Member Handbook, and the website. All requests for disenrollment are referred to SCDHHS or its designee. The effective date of an approved disenrollment request must be no later than the first day of the second month following the month in which the member filed the request.

The 2021 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description describes ATCs work to ensure that members, through the month of their 21st birthday, receive comprehensive and preventive health care and services based upon adopted practice guidelines.

### *Grievances*

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

Policy SC.MM.11, Member Grievances, the UM Program Description, Member Handbook, Provider Manual, and ATC's website define the term "grievance." Timeliness guidelines for grievance resolution are correctly documented in Policy SC.MM.11, Member Grievances, the Member Handbook, and the Provider Manual. Policy SC.MM.11, Member Grievances, explains all member grievances are reviewed by the Quality Improvement Department to identify trends and opportunities for improvement. ATC tracks and

monitors member grievance data quarterly. Results and analysis are presented and discussed during QIC meetings and reflected in committee minutes.

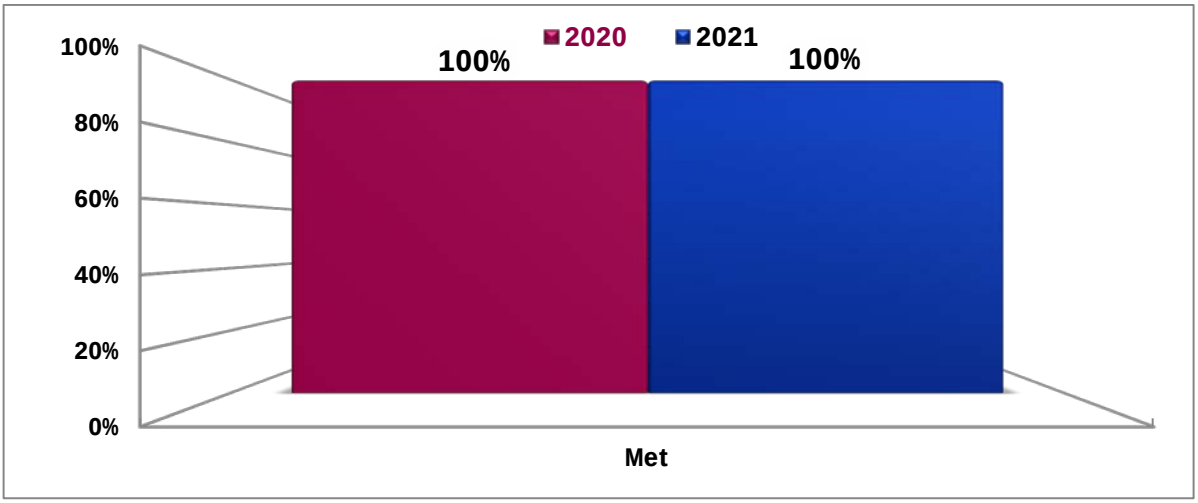
Grievance files reviewed indicated that policies and procedures are applied to the reporting, reviewing, and resolution of grievances received by and on behalf of members. Timelines and required guidelines were met for the file sample reviewed.

### *Member Satisfaction Survey*

ATC contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct both the Child and Adult surveys. The QIC minutes from August 2021 document the discussion of CAHPS results and analysis. The Child survey response rate was 9.4% (240 out of 2546 surveys) which is a decline from the previous year's rate of 11.8% (302 completed out of 2552). The Adult response rate was 12.1% (228 out of 1878 surveys) which is a slight decline from the previous year's rate of12.4% (233 out of 1,881 surveys). The Child CCC response rate was 9.6% (158 out of 1646), which is a decline from last year's response rate of 14.0% (230 out of 1647). The minimum number of completed surveys is less than the NCQA target of 411 surveys for all three populations: Adult, Child, and Child CCC. The response rates are also below the NCQA target rate of 40%.

*Figure 5: Member Services Findings* reflects that 100% of the Member Services standards were scored as "Met."

**Figure 5: Member Services Findings**




### *Strengths*

- Analyses of grievance types and/or patterns specific to providers or services are conducted and reviewed with appropriate committees in an effort to continue to improve member quality of care.

- Grievance files demonstrated timeliness of review and resolution.
- Within 14 days of enrollment, members receive a Member Welcome Packet, Welcome Call, and Member Handbook detailing their rights, responsibilities, and access to services.

### *Weaknesses*

- ATCs Member Satisfaction survey response rates have decline over the past three survey cycles.

### *Recommendations*

- Continue conducting a barriers analysis to determine the issues with obtaining survey responses as response rates have decline over the past three survey cycles.

## D. Quality Improvement

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

ATC's Quality Improvement (QI) Program is designed to monitor, evaluate, and improve the quality of care and services provided to all members. The QI Program is managed at the health plan and no activities are delegated. The 2021 Quality Program Description – Medicaid/Marketplace was submitted for review. The scope of work described in the program description includes areas such as preventive health, acute and chronic care, over and underutilization, population health management, behavioral health, continuity and coordination of care, accessibility and availability of care, member services, patient safety, HEDIS and CAHPS results, provider satisfaction, and health outcomes. On an annual basis, the Quality Department reviews the Quality Program Description and revises as needed.

Annually, ATC makes information about its Quality Program available to members and practitioners. ATC's website contained several resources explaining the Quality Program and directions for calling with additional questions.

ATC develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. ATC presented the 2020 and 2021 QI Work Plans for review. Both are reviewed and updated at least quarterly. The work plans included the standard/scope, objective, a description of activities, responsible person(s), timeline/frequency, and each activity's status. ATC also addressed previously identified issues and opportunities. The objective for the delegation section of the work plan (page 26) mentions "ATC will maintain oversight of all functions performed by delegated entities." The Delegation activities listed on page 26 of the 2021 Work Plan only included the oversight for NIA and Envolve Benefit Options, Envolve People Care, and Envolve

Pharmacy Solutions. Delegation for the credentialing activities was not included. Also, the annual NIA audit was the only activity listed as completed.

ATC's Quality Improvement Committee (QIC) is the senior management committee accountable to the Board of Directors. The QIC provides oversight and direction in assessing the appropriateness of care and service delivery. Each internal department participates and contributes to the Program and works collaboratively on QI activities. The QI Program Description outlines ATC's committee structure and committee charters for the QIC and other subcommittees.

The QIC is chaired by the Chief Medical Officer. Other members include senior management staff, network practitioners, and other support staff. All senior staff and network physicians are considered voting members. Three voting members including the Senior Quality Improvement Executive, one ATC staff, and one external practitioner must be present for a quorum.

The QIC meetings are held no less than quarterly. Detailed records and minutes for all meetings are maintained. The committee minutes were complete, signed, and dated by the recorder and the chair. Meeting minutes are reviewed and approved at the next meeting of the committee. Copies of the committee minutes provided by ATC demonstrated the committees met at quarterly intervals.

ATC offers a quality, cost, and utilization tool designed to support providers who participate in a value-based program in order to identify provider performance opportunities and to assist with population health management initiatives. Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts. ATC also offers a provider report card that focuses on pediatric measures. ATC did not send the provider report cards in 2021 due to the changes in the well child measures and true benchmarks not being available. Providers were notified of this change and rates were made available on ATC's website.

ATC evaluated the effectiveness of the QI program and activities conducted in 2020 and provided CCME with a copy of this formal evaluation. The 2020 Quality Program Evaluation included a summary and results for each quality activity, any barriers identified, and opportunities for improvement. The Delegated Vendor Oversight section (page 43) appeared incomplete. The oversight for Envolve Benefit Options, Envolve People Care, and Envolve Pharmacy Solutions was not included in the results. Also, only the credentialing oversight for NIA was reported.

## *Performance Measure Validation*

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

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. ATC uses a certified software organization for calculation of HEDIS rates. The performance measure validation found that ATC 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 for the current review year (2021), as well as the previous year (2020) and the change from 2020 to 2021 are reported in *Table 12: HEDIS Performance Measure Results*. A change in rates shown in green indicates a substantial (>10%) improvement and those rates shown in red indicate a substantial (>10%) decline.

**Table 12: HEDIS Performance Measure Results**

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 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* | 87.59% | 73.48% | -14.11% |
| *Counseling for Nutrition* | 72.26% | 61.07% | -11.19% |
| *Counseling for Physical Activity* | 67.40% | 57.18% | -10.22% |
| *DTaP* | 72.26% | 69.59% | -2.67% |
| *IPV* | 90.75% | 85.4% | -5.35% |
| *MMR* | 87.59% | 86.13% | -1.46% |
| *HiB* | 82.48% | 79.56% | -2.92% |
| *Hepatitis B* | 90.27% | 83.7% | -6.57% |
| *VZV* | 86.62% | 85.89% | -0.73% |
| *Pneumococcal Conjugate* | 78.35% | 72.75% | -5.60% |
| *Hepatitis A* | 85.16% | 83.94% | -1.22% |
| *Rotavirus* | 73.97% | 70.07% | -3.90% |
| *Influenza* | 39.90% | 41.36% | 1.46% |
| *Combination #2* | 67.88% | 64.96% | -2.92% |
| *Combination #3* | 65.94% | 63.26% | -2.68% |
| *Combination #4* | 64.96% | 62.04% | -2.92% |
| *Combination #5* | 57.18% | 55.96% | -1.22% |
| *Combination #6* | 32.85% | 34.79% | 1.94% |
| *Combination #7* | 56.69% | 55.23% | -1.46% |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Combination #8* | 32.60% | 34.79% | 2.19% |
| *Combination #9* | 28.95% | 31.14% | 2.19% |
| *Combination #10* | 28.71% | 31.14% | 2.43% |
| Immunizations for Adolescents (ima) | | | |
| *Meningococcal* | 72.02% | 70.56% | -1.46% |
| *Tdap/Td* | 82.00% | 82.24% | 0.24% |
| *Combination #1* | 71.05% | 69.83% | -1.22% |
| *Combination #2* | 31.39% | 29.93% | -1.46% |
| Human Papillomavirus Vaccine for Female Adolescents (hpv) | 32.36% | 31.63% | -0.73% |
| Lead Screening in Children (lsc) | 68.35% | 67.85% | -0.50% |
| Breast Cancer Screening (bcs) | 62.64% | 57.55% | -5.09% |
| Cervical Cancer Screening (ccs) | 65.94% | 59.61% | -6.33% |
| Chlamydia Screening in Women (chl) | | | |
| *16-20 Years* | 59.55% | 59.98% | 0.43% |
| *21-24 Years* | 66.48% | 63.92% | -2.56% |
| *Total* | 61.47% | 61.34% | -0.13% |
| **Effectiveness of Care: Respiratory Conditions** | | | |
| Appropriate Testing for Pharyngitis (cwp) | | | |
| *3-17 years* | 83.27% | 84.01% | 0.74% |
| *18-64* | 71.60% | 73.42% | 1.82% |
| *65+* | 70.59% | 50% | -20.59% |
| *Total* | 81.09% | 81.69% | 0.60% |
| Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr) | 26.65% | 27.44% | 0.79% |
| Pharmacotherapy Management of COPD Exacerbation (pce) | | | |
| *Systemic Corticosteroid* | 63.22% | 69.26% | 6.04% |
| *Bronchodilator* | 78.11% | 80.42% | 2.31% |
| Asthma Medication Ratio (amr) | | | |
| *5-11 Years* | 79.72% | 81.77% | 2.05% |
| *12-18 Years* | 71.72% | 75% | 3.28% |
| *19-50 Years* | 60.16% | 49.66% | -10.50% |
| *51-64 Years* | 61.84% | 48.24% | -13.60% |
| *Total* | 72.68% | 70.89% | -1.79% |
| **Effectiveness of Care: Cardiovascular Conditions** | | | |
| Controlling High Blood Pressure (cbp) | 50.85% | 51.34% | 0.49% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | 79.37% | 68.89% | -10.48% |
| Statin Therapy for Patients With Cardiovascular Disease (spc) | | | |
| *Received Statin Therapy - 21-75 years (Male)* | 79.47% | 81.82% | 2.35% |
| *Statin Adherence 80% - 21-75 years (Male)* | 59.41% | 62.57% | 3.16% |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Received Statin Therapy - 40-75 years (Female)* | 80.46% | 79.19% | -1.27% |
| *Statin Adherence 80% - 40-75 years (Female)* | 63.97% | 62.71% | -1.26% |
| *Received Statin Therapy - Total* | 79.94% | 80.73% | 0.79% |
| *Statin Adherence 80% - Total* | 61.58% | 62.63% | 1.05% |
| Cardiac Rehabilitation (CRE) | | | |
| *Cardiac Rehabilitation - Initiation (18-64)* | NR | 4.1% | NA |
| *Cardiac Rehabilitation - Engagement1 (18-64)* | NR | 3.59% | NA |
| *Cardiac Rehabilitation - Engagement2 (18-64)* | NR | 3.59% | NA |
| *Cardiac Rehabilitation - Achievement (18-64)* | NR | 1.03% | NA |
| *Cardiac Rehabilitation - Initiation (65+)* | NR | 9.52% | NA |
| *Cardiac Rehabilitation - Engagement1 (65+)* | NR | 9.52% | NA |
| *Cardiac Rehabilitation - Engagement2 (65+)* | NR | 9.52% | NA |
| *Cardiac Rehabilitation - Achievement (65+)* | NR | 9.52% | NA |
| *Cardiac Rehabilitation - Initiation (Total)* | NR | 5.06% | NA |
| *Cardiac Rehabilitation - Engagement1 (Total)* | NR | 4.64% | NA |
| *Cardiac Rehabilitation - Engagement2 (Total)* | NR | 4.64% | NA |
| *Cardiac Rehabilitation - Achievement (Total)* | NR | 2.53% | NA |
| **Effectiveness of Care: Diabetes** | | | |
| Comprehensive Diabetes Care (cdc) | | | |
| *Hemoglobin A1c (HbA1c) Testing* | 91.06% | 88.08% | -2.98% |
| *HbA1c Poor Control (>9.0%)* | 41.42% | 44.04% | 2.62% |
| *HbA1c Control (<8.0%)* | 49.27% | 47.69% | -1.58% |
| *Eye Exam (Retinal) Performed* | 57.85% | 47.2% | -10.65% |
| *Medical Attention for Nephropathy* | 91.42% | NR | NA |
| *Blood Pressure Control (<140/90 mm Hg)* | 55.66% | 52.55% | -3.11% |
| Kidney Health Evaluation for Patients With Diabetes (KED) | | | |
| *Kidney Health Evaluation for Patients With Diabetes (18-64)* | NR | 21.56% | NA |
| *Kidney Health Evaluation for Patients With Diabetes (65-74)* | NR | 25.71% | NA |
| *Kidney Health Evaluation for Patients With Diabetes (75-85)* | NR | 28.51% | NA |
| *Kidney Health Evaluation for Patients With Diabetes (Total)* | NR | 23.31% | NA |
| Statin Therapy for Patients With Diabetes (spd) | | | |
| *Received Statin Therapy* | 68.25% | 66.85% | -1.40% |
| *Statin Adherence 80%* | 60.30% | 59.59% | -0.71% |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| **Effectiveness of Care: Behavioral Health** | | | |
| Antidepressant Medication Management (amm) | | | |
| *Effective Acute Phase Treatment* | 43.12% | 48.3% | 5.18% |
| *Effective Continuation Phase Treatment* | 26.38% | 32.07% | 5.69% |
| Follow-Up Care for Children Prescribed ADHD Medication (add) | | | |
| *Initiation Phase* | 44.08% | 44.63% | 0.55% |
| *Continuation and Maintenance (C&M) Phase* | 59.46% | 63.28% | 3.82% |
| Follow-Up After Hospitalization for Mental Illness (fuh) | | | |
| *6-17 years - 30-Day Follow-Up* | 70.48% | 74.02% | 3.54% |
| *6-17 years - 7-Day Follow-Up* | 45.18% | 50.89% | 5.71% |
| *18-64 years - 30-Day Follow-Up* | 47.86% | 54.6% | 6.74% |
| *18-64 years - 7-Day Follow-Up* | 27.78% | 33.09% | 5.31% |
| *65+ years - 30-Day Follow-Up* | NA | NA | NA* |
| *65+ years - 7-Day Follow-Up* | NA | NA | NA* |
| *30-Day Follow-Up* | 53.48% | 60.69% | 7.21% |
| *7-Day Follow-Up* | 31.67% | 38.5% | 6.83% |
| Follow-Up After Emergency Department Visit for Mental Illness (fum) | | | |
| *6-17 years - 30-Day Follow-Up* | 68.09% | 70.76% | 2.67% |
| *6-17 years - 7-Day Follow-Up* | 44.07% | 55.56% | 11.49% |
| *18-64 years - 30-Day Follow-Up* | 47.20% | 42.7% | -4.50% |
| *18-64 years - 7-Day Follow-Up* | 31.90% | 27.81% | -4.09% |
| *65+ years - 30-Day Follow-Up* | NA | NA | NA* |
| *65+ years - 7-Day Follow-Up* | NA | NA | NA* |
| *30-Day Follow-Up* | 55.47% | 51.93% | -3.54% |
| *7-Day Follow-Up* | 36.78% | 37.06% | 0.28% |
| Follow-Up After High-Intensity Care for Substance Use Disorder (fui) | | | |
| *13-17 years - 30-Day Follow-Up* | NA | NA | NA* |
| *13-17 years - 7-Day Follow-Up* | NA | NA | NA* |
| *18-64 years - 30-Day Follow-Up* | 39.65% | 42.64% | 2.99% |
| *18-64 years - 7-Day Follow-Up* | 28.63% | 23.35% | -5.28% |
| *65+ years - 30-Day Follow-Up* | NA | NA | NA* |
| *65+ years - 7-Day Follow-Up* | NA | NA | NA* |
| *Total - 30-Day Follow-Up* | 40.71% | 40% | -0.71% |
| *Total - 7-Day Follow-Up* | 29.25% | 22.67% | -6.58% |
| Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) | | | |
| *13-17 years - 30-Day Follow-Up* | NA | NA | NA |
| *13-17 years - 7-Day Follow-Up* | NA | NA | NA |
| *18+ years - 30-Day Follow-Up* | 11.91% | 12.5% | 0.59% |
| *18+ years - 7-Day Follow-Up* | 7.19% | 9.25% | 2.06% |
| *Total - 30-Day Follow-Up* | 11.81% | 12.29% | 0.48% |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Total - 7-Day Follow-Up* | 7.09% | 8.98% | 1.89% |
| Pharmacotherapy for Opioid Use Disorder (pod) | | | |
| *16-64 years* | 48.69% | 40.94% | -7.75% |
| *65+ years* | NA | NA | NA* |
| *Total* | 48.38% | 40.31% | -8.07% |
| Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd) | 76.71% | 75.13% | -1.58% |
| Diabetes Monitoring for People With Diabetes and Schizophrenia (smd) | 72.88% | 66.29% | -6.59% |
| Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)* | NA | NA | NA* |
| Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa) | 64.11% | 63.81% | -0.30% |
| Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) | | | |
| *Blood glucose testing - 1-11 Years* | 41.51% | 32.12% | -9.39% |
| *Cholesterol Testing - 1-11 Years* | 28.30% | 21.9% | -6.40% |
| *Blood glucose and Cholesterol Testing - 1-11 Years* | 25.47% | 21.17% | -4.30% |
| *Blood glucose testing - 12-17 Years* | 51.85% | 56.41% | 4.56% |
| *Cholesterol Testing - 12-17 Years* | 30.16% | 30.77% | 0.61% |
| *Blood glucose and Cholesterol Testing - 12-17 Years* | 24.87% | 29.74% | 4.87% |
| *Blood glucose testing - Total* | 48.14% | 46.39% | -1.75% |
| *Cholesterol Testing - Total* | 29.49% | 27.11% | -2.38% |
| *Blood glucose and Cholesterol Testing - Total* | 25.08% | 26.2% | 1.12% |
| **Effectiveness of Care: Overuse/Appropriateness** | | | |
| Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs) | 1.90% | 1.46% | -0.44% |
| Appropriate Treatment for Children With URI (uri) | | | |
| *3 months-17 Years* | 57.45% | 62.44% | 4.99% |
| *18-64 Years* | 34.23% | 33.92% | -0.31% |
| *65+ Years* | 24.16% | 16.33% | -7.83% |
| *Total* | 49.22% | 52.92% | 3.70% |
| Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab) | | | |
| *3 months-17 Years* | 57.45% | 62.44% | 4.99% |
| *18-64 Years* | 34.23% | 33.92% | -0.31% |
| *65+ Years* | 24.16% | 16.33% | -7.83% |
| *Total* | 49.22% | 52.92% | 3.70% |
| Use of Imaging Studies for Low Back Pain (lbp) | 69.69% | 69.25% | -0.44% |
| Use of Opioids at High Dosage (hdo) | 2.71% | 2.49% | -0.22% |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| Use of Opioids From Multiple Providers (uop) | | | |
| *Multiple Prescribers* | 17.96% | 15.4% | -2.56% |
| *Multiple Pharmacies* | 5.55% | 3.33% | -2.22% |
| *Multiple Prescribers and Multiple Pharmacies* | 2.33% | 1.35% | -0.98% |
| Risk of Continued Opioid Use (cou) | | | |
| *18-64 years - >=15 Days covered* | 4.02% | 4.07% | 0.05% |
| *18-64 years - >=31 Days covered* | 2.18% | 1.9% | -0.28% |
| *65+ years - >=15 Days covered* | 16.12% | 14.81% | -1.31% |
| *65+ years - >=31 Days covered* | 7.21% | 8.13% | 0.92% |
| *Total - >=15 Days covered* | 5.39% | 5.38% | -0.01% |
| *Total - >=31 Days covered* | 2.75% | 2.66% | -0.09% |
| **Access/Availability of Care** | | | |
| Adults' Access to Preventive/Ambulatory Health Services (aap) | | | |
| *20-44 Years* | 76.92% | 75.13% | -1.79% |
| *45-64 Years* | 85.35% | 83.35% | -2.00% |
| *65+ Years** | 91.79% | 89.59% | -2.20% |
| *Total* | 81.93% | 79.56% | -2.37% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years** | NA | NA | NA* |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years** | NA | NA | NA* |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years** | NA | NA | NA* |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years** | NA | NA | NA* |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years* | 32.64% | 42.11% | 9.47% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years* | 15.28% | 10.53% | -4.75% |
| *Initiation of AOD Treatment: 13-17 Years* | 33.33% | 40.28% | 6.95% |
| *Engagement of AOD Treatment: 13-17 Years* | 15.38% | 9.72% | -5.66% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years* | 40.55% | 45.49% | 4.94% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 7.21% | 7.14% | -0.07% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years* | 43.93% | 59.36% | 15.43% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 19.08% | 31.53% | 12.45% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years* | 38.79% | 43.04% | 4.25% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 7.84% | 9.22% | 1.38% |
| *Initiation of AOD Treatment: 18+ Years* | 39.61% | 45.41% | 5.80% |

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | PERCENTAGE POINT DIFFERENCE |
|---|---|---|---|
| *Engagement of AOD Treatment: 18+ Years* | 9.85% | 12.13% | 2.28% |
| *Alcohol abuse or dependence: Initiation of AOD Treatment: Total* | 40.45% | 45.32% | 4.87% |
| *Alcohol abuse or dependence: Engagement of AOD Treatment: Total* | 7.47% | 7% | -0.47% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: Total* | 43.95% | 59.46% | 15.51% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 19.19% | 31.45% | 12.26% |
| *Other drug abuse or dependence: Initiation of AOD Treatment: Total* | 38.11% | 42.93% | 4.82% |
| *Other drug abuse or dependence: Engagement of AOD Treatment: Total* | 8.67% | 9.37% | 0.70% |
| *Initiation of AOD Treatment: Total* | 39.21% | 45.08% | 5.87% |
| *Engagement of AOD Treatment: Total* | 10.20% | 11.97% | 1.77% |
| Prenatal and Postpartum Care (ppc) | | | |
| *Timeliness of Prenatal Care* | 93.67% | 89.54% | -4.13% |
| *Postpartum Care* | 78.83% | 76.89% | -1.94% |
| Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app) | | | |
| *1-11 Years* | 54.55% | 51.79% | -2.76% |
| *12-17 Years* | 61.00% | 54.88% | -6.12% |
| *Total* | 58.71% | 53.62% | -5.09% |
| **Utilization** | | | |
| Well-Child Visits in the First 15 Months of Life (w15) | | | |
| *Well-Child Visits in the First 30 Months of Life (First 15 Months)* | NR | 50.75% | NA |
| *Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)* | NR | 69.74% | NA |
| Child and Adolescent Well-Care Visits (WCV) | | | |
| *Child and Adolescent Well-Care Visits (3-11)* | NR | 47.26% | NA |
| *Child and Adolescent Well-Care Visits (12-17)* | NR | 43.2% | NA |
| *Child and Adolescent Well-Care Visits (18-21)* | NR | 20.36% | NA |
| *Child and Adolescent Well-Care Visits (Total)* | NR | 43.17% | NA |

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

As noted in *Table 13: HEDIS Measures with Substantial Changes in Rates*, the comparison from the previous to the current year revealed a strong increase (>10%) in several rates as well as a substantial decline (>10%) in several rates.

Table 13: HEDIS Measures with Substantial Changes in Rates

| MEASURE/DATA ELEMENT | HEDIS 2020 | HEDIS 2021 | Change from 2020 to 2021 |
|---|---|---|---|
| Substantial Increase in Rate (>10% improvement) | | | |
| Follow-Up After Emergency Department Visit for Mental Illness (fum) | | | |
| *6-17 years - 7-Day Follow-Up* | 44.07% | 55.56% | 11.49% |
| Initiation and Engagement of AOD Dependence Treatment (iet) | | | |
| *Opioid abuse or dependence: Initiation of AOD Treatment18+ Years* | 43.93% | 59.36% | 15.43% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years* | 19.08% | 31.53% | 12.45% |
| *Opioid abuse or dependence: Initiation of AOD Treatment: Total* | 43.95% | 59.46% | 15.51% |
| *Opioid abuse or dependence: Engagement of AOD Treatment: Total* | 19.19% | 31.45% | 12.26% |
| Substantial Decrease in Rate (>10% decrease) | | | |
| Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc) | | | |
| *BMI Percentile* | 87.59% | 73.48% | -14.11% |
| *Counseling for Nutrition* | 72.26% | 61.07% | -11.19% |
| *Counseling for Physical Activity* | 67.40% | 57.18% | -10.22% |
| Appropriate Testing for Pharyngitis (cwp) | | | |
| *65+ Years* | 70.59% | 50% | -20.59% |
| Asthma Medication Ratio (amr) | | | |
| *19-50 Years* | 60.16% | 49.66% | -10.50% |
| *51-64 Years* | 61.84% | 48.24% | -13.60% |
| Persistence of Beta-Blocker Treatment After a Heart Attack (pbh) | 79.37% | 68.89% | -10.48% |
| Comprehensive Diabetes Care (cdc) | | | |
| *Eye Exam (Retinal) Performed* | 57.85% | 47.2% | -10.65% |

## *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, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

- Study topic(s)
- Study question(s)
- Study indicator(s)
- Identified study population

- Sampling methodology (if used)
- Data collection procedures
- Improvement strategies

For this review, three PIPs were submitted with topics of Postpartum Care, Provider Satisfaction, and Hospital Readmissions. The Postpartum Care PIP was retired and therefore not included in this validation. The remaining two PIPs scored in the "High Confidence in Reported Results" range. The reported rates for the provider satisfaction and readmission PIP showed improvements in the rates and interventions were effective. The tables that follow provide an overview of the previous validation scores with the current scores. A summary of each PIP's status and the interventions are also included.

**Table 14: Provider Satisfaction PIP**

| Provider Satisfaction | |
|---|---|
| The objective for the Provider Satisfaction is to identify opportunities and implement initiatives to positively impact provider satisfaction and meet or exceed the plan's goal of the 75th percentile as defined by the SPH Analytics Medicaid Book of Business. The 2018, 2019, and 2020 rates were included in the PIP report for Overall Satisfaction with Absolute Total Care showing a reduction from 73.4% in 2018 to 57.9% in 2019 which then improved to 68% in 2020. This is below the goal rate of 75th percentile for Book of Business. | |
| **Previous Validation Score** | **Current Validation Score** |
| 87/88=99%<br>High Confidence in Reported Results | 100/100=100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Monthly roster updates and quarterly batch loads serves to mitigate provider abrasion with inaccurate enrollment data which causes claims payment inaccuracy.<br>• Workgroup meetings to review and expedite claims adjustments and claims reconsiderations.<br>• Robust training and orientation for Provider relations and Customer Service Representatives. Leads from other functional areas attend team meetings to present on their scope and processes to familiarize the staff on additional business functions.<br>• Provider education with quarterly virtual Town Hall meetings and developing and distributing educational materials on the provider portal and online tools to include how to access the formulary. | |

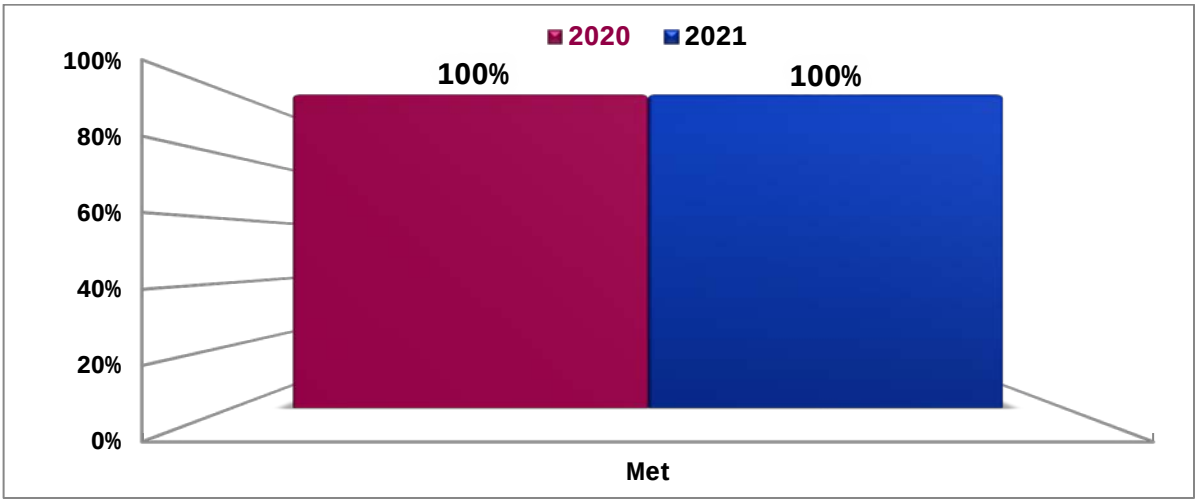
**Table 15: Hospital Readmissions PIP**

| Hospital Readmissions | |
|---|---|
| The health plan's overall rate for readmissions for the previous twelve months was 18.0% with several months during that period having a rate greater than 18.0%. After analysis of the data, ATC's department leaders and QIC identified an opportunity for improvement in reducing readmissions and a PIP was approved. The goal set internally for this PIP is to reduce the readmission rate to 17.5%. Data were reported for the baseline and Remeasurement 1. The results show a decline in readmissions from 18% to 16.2% in the 2020/2021 measure. These results indicate improvement in reducing readmission and exceed the goal rate of 17.5%. | |
| **Previous Validation Score** | **Current Validation Score** |
| 72/72=100%<br>High Confidence in Reported Results | 80/80= 100%<br>High Confidence in Reported Results |
| **Interventions** | |
| • Transition of Care (TOC) team assesses members upon discharge and reviews the discharge summary, assists member with scheduling appointment within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmission. Quarterly meetings with managers and the TOC team to discuss the TOC process.<br>• Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions<br>• For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP.<br>• Members at risk for readmission based on most frequently admitted diagnosis are referred to the Case Manager or to Intensive Care Coordination for outreach if not actively enrolled in case management.<br>• Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meet quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members.<br>• UM Manager pulls daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met. | |

Details of the validation of the performance measures and performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3*.

ATC 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*

- ATC addresses any previously identified issues and opportunities for improvement in the QI Work Plan and in the QI Program Evaluation.
- ATC's HEDIS measures were compliant and met the validation requirements.
- The reported rates for the provider satisfaction and readmission performance improvement projects showed improvement in the rates, and interventions were effective.
- The performance improvement projects scored within the "High Confidence Range" and met all validation requirements.
- Provider analytics offers a quality, cost, and utilization tool for providers to identify performance opportunities, and to assist with population health management. This tool prioritizes measures based on providers' performance to help identify where to focus clinical efforts.

### *Weaknesses*

- The Delegation activities listed on page 26 of the 2021 Work Plan did not include oversight for all delegated entities.
- The Delegated Vendor Oversight section (page 43) of the 2020 QI Program Evaluation appeared incomplete. The oversight for Envolve Benefit Options, Envolve People Care, and Envolve Pharmacy Solutions was not included in the results. Also, only the credentialing oversight for NIA was reported.

***Recommendations:***

- Include the oversight monitoring of all functions performed by a delegated entity in the QI Work Plan.
- Include the results of the oversight monitoring of all functions performed by a delegated entity in the QI program evaluation.

## 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)*

ATC has a comprehensive Utilization Management (UM) Program Description along with numerous policies and procedures that guide staff in the implementation of utilization management functions. The daily oversight and operating authority of UM activities is delegated to the Utilization Management Committee (UMC). This committee is responsible for the review and approval of medical necessity criteria, protocols, and UM policies and procedures. The UMC also coordinates the annual review and revision of the UM Program Description and the annual UM Program Evaluation. The Chief Medical Director oversees all aspects of the UM Program. A Medical Director with a specialty in Psychiatry oversees activities related to behavioral health, and a registered Pharmacist oversees the implementation, monitoring, and directing of pharmacy services.

Per Policy SC.UM.54, Preferred Provider Designation, ATC allows a provider and/or institution recognized for consistently managing care based on quality and practice guidelines to become eligible for the Preferred Provider Designation. This designation allows the provider to be exempt from prior authorizations; or eligible for expedited prior authorization processing; or eligible for simplified/minimal documentation in their submission of prior authorization requests. The preferred provider status designation is reviewed annually. There are currently four providers designated as a preferred provider.

The review of approval and denial files confirms ATC performs reviews using appropriate criteria with notification of determinations promptly communicated to the provider and member, as applicable. Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-rater Reliability testing. Recent results confirm scores above the 90 percent benchmark were obtained by all staff.

The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List (PDL) changes on ATC's website at least 30 days prior to implementation. Policy CC.PHAR.10, Preferred Drug List, includes this contract language. However, it lacked the process used to ensure these changes are published on the

website. Notices for PDL changes were found on ATC's website; however, some of the issues identified with this notification included:

- The Pharmacy and Therapeutics (P&T) Committee met and approved the PDL changes after the effective date of the change. For example, 2nd quarter 2020 changes had an effective date of March 1, 2020. The changes were discussed at the P&T Committee meeting held on March 7, 2020.
- 1st quarter 2021 changes had an effective date of February 1, 2021. These changes were discussed at the P&T Committee meeting on January 12, 2021, which only gave a 20-day notice. Also, there were PDL changes discussed during the meeting and not included on the website notice.
- Several changes noted in the 1st quarter 2021 P&T Committee meeting minutes (meeting date January 12, 2021) had an effective date of December 1, 2020; however, no notice was found on the website (Procysbi and Rukobia). Semglee was discussed during the January 12, 2021, P&T meeting and posted on the website; however, the effective date was January 1, 2021, which was before the committee met.

UM denial files reflected timely decisions and notifications. Adverse Benefit Determination letters were written in appropriate language for ease of member understanding, contained the rationale for the denial along with references to the criteria used, and supplied information on how to request an appeal. Overall, the denial decisions were made by an appropriate physician specialist. However, there were four cases that were questionable. For example, a pediatrician reviewed and denied an epidural steroid injection for an adult, and genetic testing reviewed by a general surgeon and internal medicine. ATC explained the physician reviewers have access to consult with other physician specialties within Centene and through Advance Medical Reviews.

### *Appeals*

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

Policy SC.UM.13, Member Appeals, describes ATC's process for resolving member disputes and responding to member appeal requests. Information on the appeals process is also found in the Member Handbook and Provider Manual. Appeals are resolved and resolutions provided within 30 calendar days of receipt for standard appeals and within 72 hours of receipt for expedited appeals. If a request for expedited appeal is denied, the member is notified, and the appeal is processed within the standard 30-day timeframe.

ATC provided copies of the letter templates used for appeal requests. One letter template (MbrNegResLtr-A), provided to the member when ATC cannot process the appeal request, does not provide the member with their right to file a State Fair Hearing. The letter sent to members when an oral request for an appeal is made

(MbrOralReqFormSC) incorrectly mentions a written appeal request must be received following receipt of an oral appeal request. According to staff, these letters are rarely used and agreed with the changes.

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

### *Care Management and Coordination*

*42 CFR § 208, 42 CFR § 457.1230 (c)*

ATC's 2021 Care Management Program Description includes the program's purpose, scope, and infrastructure. Also included is information about member identification, initial screening, and ongoing assessments and management. The Population Health Management Strategy Guide: 2021 describes the Population Health Management (PHM) Program and provides information about program goals and priorities, member programs and services, population identification and assessment, etc. Policies and procedures provide additional detail about Care Management (CM) processes and requirements.

ATC's Care Management Program is based on evidence-based guidelines and uses the Case Management Society of America (CMSA) Standards of Practice for Case Management. The program follows the concepts, theory, and skills for Person Centered Practices as defined by Center for Medicare and Medicaid Services, National Quality Forum and The Learning Community for Person Centered Practices. CM staff are trained in person-centered thinking and motivational interviewing to guide member goal identification and actions. An integrated care management model is used, and members are assigned a single point of contact, such as a primary Care Manager. The primary Care Manager is supported by a multidisciplinary Care Team which may include Medical Directors, licensed social workers, other licensed medical or behavioral health professionals, Program Coordinators, Member Connections Representatives, and Community Health Services Representatives.

ATC conducts annual surveys to provide an opportunity for members who have been enrolled in CM to give feedback about satisfaction with the program, and an annual evaluation of the CM Program is conducted. Problems and/or concerns are identified along with recommendations for removing barriers and opportunities to improve member

and provider experience. The evaluation and recommendations are submitted to the QIC or other appropriate committee for review, action, and follow-up.

The Population Health Management Impact Annual Report: 2020 indicates that for 2020, the goal satisfaction rate was met for all questions except one: "Did your Care Manager help you get the healthcare services that you needed?" Barriers and opportunities for improvement were identified, and as a result, ATC implemented the refresher trainings on Person-Centered Case Management Model for all case managers (Q3 2021), refresher Motivational Interviewing Training for all case managers (Q2 2021), and implementation of an enhanced Aunt Bertha platform to assist case management team in identifying community resources for members (Q3 2021).

Overall, CM files reflected care management and coordination activities are conducted as required. For one file, the Complex Care Management Assessment indicated the member reported concerns about food availability/money for food in the past 12 months. However, the assessment note on page 12 of the assessment states, "No economic and social conditions (SDOH) have been identified for member at this time that may impact ability to meet health care and case management goals." The care plan did not include this as a barrier or concern and there was no documentation of referrals to support services or community resources.

As noted in *Figure 7: Utilization Management Findings*, ATC achieved "Met" scores for 98% of the UM standards and 2% were scored as "Partially Met." The standard related to publishing negative PDL changes on ATC's website was the only standard that received a "Partially Met" score.

**Figure 7: Utilization Management Findings**

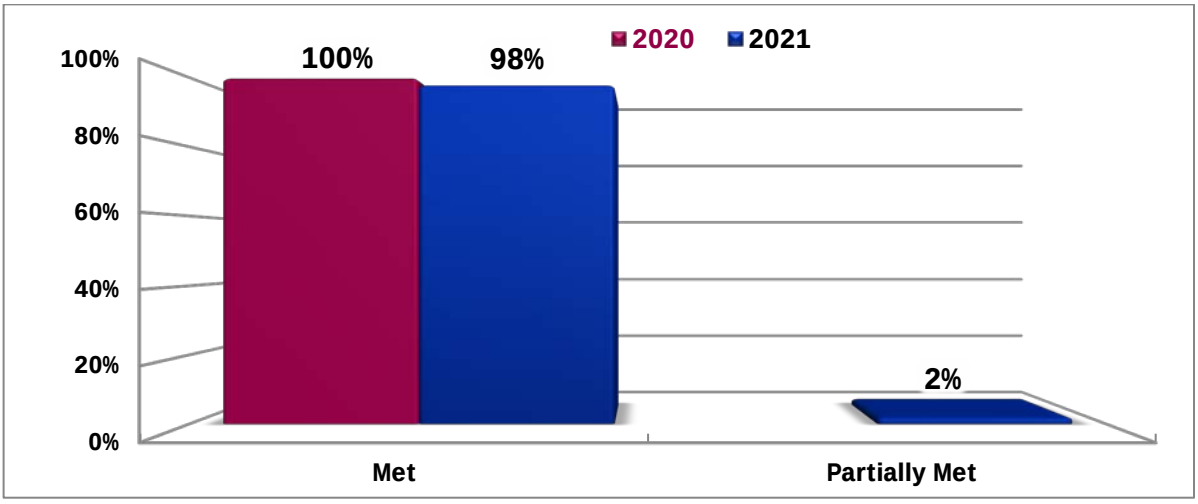


**TABLE 16: Utilization Management Comparative Data**

| SECTION | STANDARD | 2020 REVIEW | 2021 REVIEW |
|---|---|---|---|
| Pharmacy Requirements | Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts. | Met | Partially Met |

*The standards reflected in the table are only the standards that showed a change in score from 2020 to 2021.*

### *Strengths*

- Utilization management decisions were timely, and members were notified of these decisions appropriately.
- UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
- Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-rater Reliability testing. Recent results confirm scores above the 90 percent benchmark were obtained by all staff.
- Analysis of over and under-utilization was comprehensive and demonstrates a focus on monitoring, evaluating, and addressing utilization issues.
- ATC's Care Management Program is based on evidence-based guidelines and uses the Case Management Society of America Standards of Practice for Case Management. The program follows the concepts, theory, and skills for Person Centered Practices as defined by the Center for Medicare and Medicaid Services, National Quality Forum and The Learning Community for Person Centered Practices.
- CM staff are trained in person-centered thinking and motivational interviewing to guide member goal identification and actions.

### *Weaknesses*

- The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative PDL changes on the ATC website at least 30 days prior to implementation. Policy CC.PHAR.10, Preferred Drug List, includes this contract requirement. The policy lacks the process used to ensure these changes are published on the website. Notices for PDL changes were found on ATC's website, however; some of the issues identified with this notification included:
  - The Pharmacy and Therapeutics (P&T) Committee met and approved the PDL changes after the effective date of the change. For example, 2nd quarter 2020 changes had an effective date of March 1, 2020. The changes were discussed at the P&T Committee meeting held on March 7, 2020.

- 1st quarter 2021 changes had an effective date of February 1, 2021. These changes were discussed at the P&T Committee meeting on January 12, 2021, which only gave a 20-day notice. Also, there were PDL changes discussed during the meeting and not included on the website notice.
- Several changes noted in the 1st quarter 2021 P&T Committee meeting minutes (meeting date January 12, 2021) had an effective date of December 1, 2020; however, no notice was found on the website (Procysbi and Rukobia). Semglee was discussed during the January 12, 2021, P&T meeting and posted on the website; however, the effective date was January 1, 2021, which was before the committee met.

- The decision to deny services in four denial files were made by an inappropriate physician specialist.
- One letter template used for appeal requests was missing the member's right to request a State Fair Hearing and another letter template incorrectly mentioned a written appeal request must be received following receipt of an oral appeal request.
- The physicians who made the appeal decision for three files did not have the appropriate clinical expertise (same or similar specialty) in treating the member's condition.
- Information about Targeted Case Management Services was not found in any of the Care Management policies.
- For one Care Management file, the Complex Care Management Assessment indicated the member reported concerns about food availability/money for food in the past 12 months. However, the related assessment note (page 12) states, "No economic and social conditions (SDOH) have been identified for member at this time that may impact ability to meet health care and case management goals." The care plan does not include this as a barrier or concern and there is no documentation of referrals to support services or community resources.

### *Quality Improvement Plans*

- Address, in a policy or desk procedure, the process for ensuring negative PDL changes are published on the website at least 30 days prior to implementation as required by the *SCDHHS Contract, Section 4.2.21.2.3*. Ensure members and their prescribing practitioners are notified at least 30 days in advance of negative PDL changes via the health plan website. Consider including the date the notices are published on the website.

### *Recommendations*

- Re-educate physician reviewers regarding the option to consult with other physician specialties within Centene and through Advance Medical Review when making denial decisions outside of their expertise. Also, document this consultation in the file.
- Review and update the appeal letter templates to ensure the letter includes the member's right to file a State Fair Hearing. Also, remove any references that require a member to submit the appeal in writing following an oral request.
- For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician.
- Include information about Targeted Case Management Services in an appropriate CM policy or program description.
- Ensure that CM files include evidence that social determinants are identified, and referrals are made to appropriate support services or community resources, as stated in Policy CC.CM.02, Care Coordination/Care Management Services.

## F. Delegation

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

CCME's review of delegation functions included the submitted delegate list, sample delegation contracts, delegation monitoring materials, and delegation oversight documentation.

ATC reported delegation agreements with 19 entities, as shown in *Table 17: Delegated Entities and Services*.

**Table 17: Delegated Entities and Services**

| Delegated Entities | Delegated Services |
|---|---|
| •Envolve People Care – Nurse Advice Line | •Member and provider calls<br>•Nurse hotline<br>•Triage |
| •Envolve People Care – Disease Management | •Disease management |
| •Envolve Pharmacy | •Service authorizations and denial letters<br>•Provider complaints<br>•Claims adjudication<br>•Network development and maintenance |
| •Envolve Vision | •Claims adjudication<br>•Provider claim appeals |

| Delegated Entities | Delegated Services |
|---|---|
| | •Credentialing and recredentialing<br>•Network development and maintenance |
| •NIA | •Service authorizations and denial letters<br>•Credentialing and recredentialing<br>•Network development and maintenance |
| •AU Medical Center/AU Medical Association<br>•Medical University of South Carolina (MUSC)<br>•Prisma Health (formerly Greenville Health System)<br>•St. Francis Physician Services, Inc. (Bon Secours)<br>•CVS Caremark Minute Clinic<br>•Management and Network Services Skilled Nursing Facility<br>•Preferred Care of Aiken<br>•Health Network Solutions<br>•Prisma Palmetto Health/University of South Carolina Medical Group<br>•AnMed Health<br>•Roper St. Francis Physicians Network<br>•Regional HealthPlus - Spartanburg<br>•Lexington County Health Services District<br>•Bons Secours Ambulatory Services – St. Francis LLC dba AFC Urgent Care | •Credentialing and recredentialing |

Processes and requirements for delegation are found in Policy SC.UM.18, Oversight of Delegated Utilization Management, and Policy CC.CRED.12, Oversight of Delegated Credentialing. Prior to implementing a delegation agreement with a subcontractor, ATC evaluates the entity to ensure it can perform the delegated activities. For approved delegates, both parties sign a written document that serves as the delegation contract and defines performance expectations for both ATC and the delegate.

ATC retains accountability for all delegated services. Formal, annual evaluations are conducted to assess delegate performance and compliance to required standards. Ongoing monitoring is conducted via routine delegate reporting and JOC meetings.

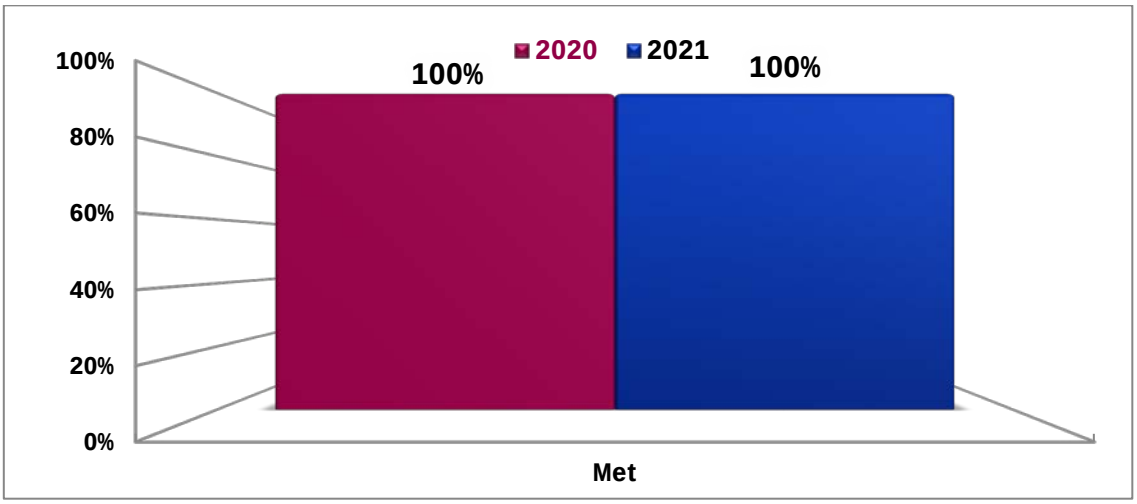
For several delegates, ATC did not submit annual oversight monitoring for 2021. Although the annual evaluations were initiated as early as May 2021, the plan reports the evaluations will not be completed until Q1 2022. These delegates included Envolve

People Care – Nurse Advice Line, Envolve People Care – Disease Management, Envolve Pharmacy, Envolve Vision, and National Imaging Associates, Inc (NIA). For these delegates, the plan submitted evidence of quarterly JOC meetings, daily output files, monthly activity reports, utilization detail and summary reports, and/or monthly and quarterly performance review reports.

Annual oversight documentation for credentialing delegates reflected ATC evaluates the delegates' policies and procedures, committee minutes, ongoing monitoring results, and conducts credentialing and recredentialing file reviews. File review tools include all required credentialing elements. Documentation of the most recent annual evaluation confirmed ATC offers recommendations, implements corrective actions as needed for any identified deficiencies, and conducts follow-up to ensure the delegates address the findings.

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

**Figure 8: Delegation Findings**




### *Strengths*

- Processes and requirements for delegation are thoroughly documented in health plan policies. Prior to implementing a delegation agreement, ATC evaluates the entity to ensure it can perform the delegated activities.

### *Weaknesses*

- Annual oversight monitoring for several delegates is untimely.

### *Recommendations*

- Complete annual delegation oversight monitoring in a timely manner.

## G. State Mandated Services

*42 CFR Part 441, Subpart B*

ATC provides all core benefits required by the *SCDHHS Contract*.

The health plan measures provider compliance with administering required immunizations and performing required EPSDT services through medical record compliance audits and HEDIS reporting measures. Interventions for improvement are initiated as needed. QI Outreach Teams conduct education and inform, track, and follow-up with members and providers to improve overall EPSDT screening rates and related HEDIS performance measures. PCPs receive monthly reports that identify EPSDT eligible members on their roster that are new to ATC and have not had an EPSDT visit. Preventive and clinical guidelines are posted on ATC's website, listed in the Provider Manual, and are available in hard copy upon request.

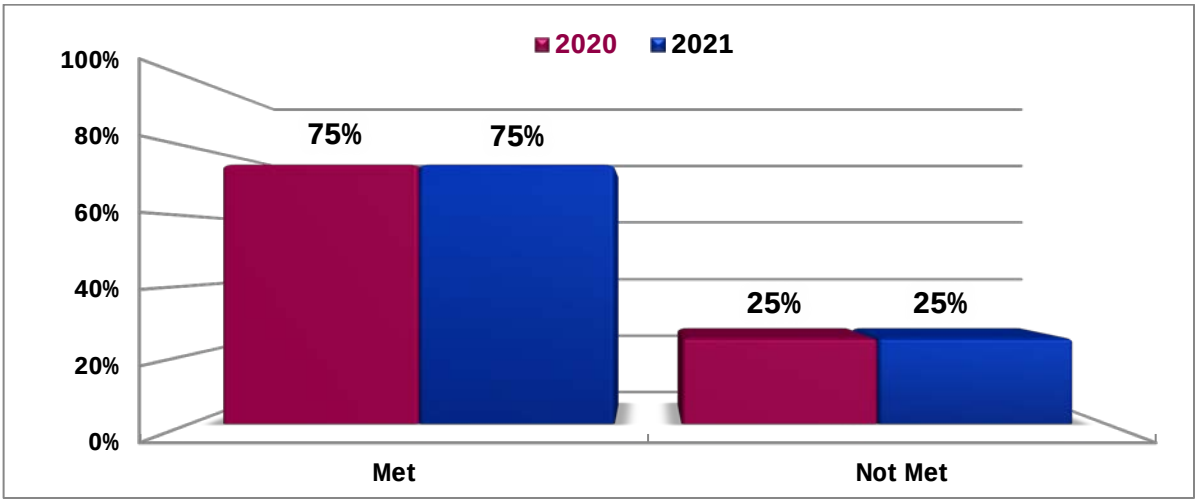
The current EQR revealed a repeated finding from the previous EQR related to inclusion of all required Status 1 providers in Geo Access mapping. See *Table 18: Previous State Mandated Services QIP Items* for ATC's response to the previous year's finding.

**Table 18: 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. | Geo Access mapping conducted on December 21, 2020 did not include the following Status 1 Provider types: General Surgery and Rehabilitative Behavioral Health. This was an issue identified in the previous EQR.<br><br>*Quality Improvement Plan: Develop and implement a monitoring process to ensure specifications for Geo Access mapping, including all Status 1 providers as, defined in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* |
| **ATC Response:** ATC will ensure when developing the Annual Network Assessment Report to run Geo Access mapping for all Status 1 providers as required and defined in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* | |

As indicated in *Figure 9: State Mandated Services*, 75% of the standards in the State Mandated Services section are scored as "Met." One standard is scored as "Not Met" due to uncorrected deficiencies from the previous EQR.

**Figure 9: State Mandated Services**




### *Strengths*

- ATC measures provider compliance by administering required immunizations and performing required EPSDT services and initiates interventions for improvement as needed. QI Outreach Teams conduct education and inform, track, and follow-up with members and providers to improve overall EPSDT screening rates and related HEDIS performance measures. PCPs receive monthly reports that identify EPSDT eligible members on their roster that are new to ATC and have not had an EPSDT visit.

### *Weaknesses*

- During the previous EQR, Geo Access mapping reports did not include all required Status 1 provider types. In the current EQR, it was again noted that the Geo Access mapping reports did not include all required Status 1 provider types. Of note, this is the third consecutive year this issue has been identified.

### *Quality Improvement Plans*

- Ensure corrections for all deficiencies identified in the EQR are addressed and fully implemented.

# ATTACHMENTS

Attachment 1: Initial Notice, Materials Requested for Desk Review

Attachment 2: Materials Requested for Onsite Review

Attachment 3: EQR Validation Worksheets

Attachment 4: Tabular Spreadsheet

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

November 29, 2021

Mr. John McClellan
President
Absolute Total Care
1441 Main Street, Suite 900
Columbia, SC 29201

Dear Mr. McClellan:

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 Absolute Total Care 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), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **January 19, 2022,** and **January 20, 2022**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **December 13, 2021.**

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 2021

### 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 2020 and 2021.

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 December 2020 through November 2021. 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 December 2020 through November 2021.

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. A listing of all delegated activities. Please include: the name of the subcontractor(s), activities delegated, and methods for oversight of the delegated activities by the MCO.

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

34. Results of the most recent monitoring activities for all delegated activities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.
35. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:
    **a. final HEDIS audit report**
    b. data collection methodology used (e.g., administrative data, including sources; medical record review, including how records were identified and how the sample was chosen;

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

36. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NP's 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 NP's 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 medical necessity denial files (acute inpatient, outpatient and behavioral health) for the months of December 2020 through November 2021. 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 December 2020 through November 2021, 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 2021

### MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copies of the most recent Geo Access mapping reports for all provider types.

3. Copy of the 4th Quarter 2020 Pharmacy and Therapeutics Committee Meeting Minutes.

## C. Attachment 3: EQR Validation Worksheets

# CCME EQR PIP Validation Worksheet

| | |
|---|---|
| **Plan Name:** | **Absolute Total Care** |
| **Name of PIP:** | **PROVIDER SATISFACTION – NON-CLINICAL** |
| **Reporting Year:** | 2021 |
| **Review Performed:** | 2022 |

## 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** | ATC provider rating of health plan was below the target rate. |
| **STEP 2: Review the PIP Aim Statement** | | |
| **2.1** Was the statement of PIP Aim(s) appropriate and adequate? **(10)** | **MET** | Aim of project was appropriate and documented. |
| **STEP 3: Identified PIP population** | | |
| **3.1** Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)** | **MET** | PIP addressed 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** | All enrolled populations were included. |
| **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** | The study used the NCQA protocol for sampling. |
| **4.2** Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:* | **MET** | The study used the NCQA protocol for sampling. |
| **4.3** Did the sample contain a sufficient number of enrollees? **(5)** | **MET** | The study used the NCQA protocol for sampling. |
| **STEP 5: Review Selected PIP Variables and Performance Measures** | | |
| **5.1** Did the study use objective, clearly defined, measurable indicators? **(10)** | **MET** | Measure was defined in report. |
| **5.2** Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)** | **MET** | Measure was focused on 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 to be collected were documented. |
| **6.2** Did the study design clearly specify the sources of data? **(1)** | **MET** | Data sources were listed. |

| 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 collection uses survey responses collected using a vendor. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Consistent and accurate data is collected. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Analysis was listed as annual survey data analysis. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Detailed information regarding staff and personnel were provided in the report. |
| **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** | Analysis was conducted according to data analysis plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were clearly presented. |
| **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 were documented in the report. |
| **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 was included in the report. |
| **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 were directly related to barriers identified. |
| **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 2018, 2019, and 2020 rates were included in the PIP report for Overall Satisfaction with Absolute Total Care showing a reduction from 73.4% in 2018 to 57.9% in 2019 which then improved to 68% in 2020. This was below the goal rate of 75$^{th}$ percentile for Book of Business. |
| **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** | The improvement was related to the interventions for education and dispute processes. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical analysis using Z scores were presented. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Unable 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 | 1 | 1 |
| 9.4 | NA | NA |

| | |
|---|---|
| **Project Score** | **100** |
| **Project Possible Score** | **100** |
| **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:** | **Absolute Total Care** |
| **Name of PIP:** | **HOSPITAL READMISSIONS - CLINICAL** |
| **Reporting Year:** | 2021 |
| **Review Performed:** | 2022 |

## 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** | Topic was selected through data collection. |
| **STEP 2: Review the PIP Aim Statement** | | |
| **2.1** Was the statement of PIP Aim(s) appropriate and adequate? **(10)** | **MET** | Aim of project was appropriate and documented. |
| **STEP 3: Identified PIP population** | | |
| **3.1** Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)** | **MET** | PIP addressed 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** | All enrolled populations were included. |
| **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)** | **NA** | Sampling not used. |
| **4.2** Did the plan employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:* | **NA** | Sampling not used. |
| **4.3** Did the sample contain a sufficient number of enrollees? **(5)** | **NA** | Sampling not used. |
| **STEP 5: Review Selected PIP Variables and Performance Measures** | | |
| **5.1** Did the study use objective, clearly defined, measurable indicators? **(10)** | **MET** | Measure was defined in report. |
| **5.2** Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)** | **MET** | Measure was focused on 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 to be collected were documented. |
| **6.2** Did the study design clearly specify the sources of data? **(1)** | **MET** | Data sources are listed. |

| 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 collection used dashboard and automated report. |
| **6.4** Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)** | **MET** | Consistent and accurate data were collected. |
| **6.5** Did the study design prospectively specify a data analysis plan? **(1)** | **MET** | Analysis was listed as annually with quarterly. |
| **6.6** Were qualified staff and personnel used to collect the data? **(5)** | **MET** | Detailed information regarding staff and personnel was provided in the report. |
| **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** | Analysis was conducted according to data analysis plan. |
| **7.2** Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)** | **MET** | Results were clearly presented. |
| **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 were documented in the report. |
| **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 was included in the report. |
| **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 were directly related to barriers identified. |
| **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 results showed a decline in readmissions from 18% to 16.2% in the 2020/2021 measure. These results indicate improvement in reducing readmission and exceed the goal rate of 17.5%. |
| **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** | The improvement was related to the interventions although tracking will continue as COVID was noted as a possible reason for lack of readmissions. |
| **9.3** Is there any statistical evidence that any observed performance improvement is true improvement? **(1)** | **MET** | Statistical analysis using chi square was documented. |
| **9.4** Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)** | **NA** | Unable 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 | NA | NA |
| 4.2 | NA | NA |
| 4.3 | NA | NA |
| **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 | 1 | 1 |
| 9.4 | NA | NA |

| | |
|---|---|
| **Project Score** | **80** |
| **Project Possible Score** | **80** |
| **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:** | **Absolute Total Care** |
| **Name of PM:** | **ALL HEDIS MEASURES** |
| **Reporting Year:** | **2020** |
| **Review Performed:** | **2022** |

| SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS |
|---|
| **HEDIS TECHNICAL SPECIFICATIONS 2021** |

| 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** | | | Plan uses NCQA certified software Quality Spectrum Insight™ from Inovalon. Audit report noted compliance for HEDIS measures. |

| 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** | **Absolute Total Care** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION- ADULT** |
| **Validation Period** | 2021 |
| **Review Performed** | 2022 |

***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. (Updated based on October 2019 version of EQR protocol 6)

## 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:* SPH Analytics Member Satisfaction Report-Adult 2021 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 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 tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Adult 2021 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 1,878. The total completed surveys were 228 for a 12.1% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is below the previous year's rate of 12.4%.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021<br><br>**Recommendation:** Consider a barriers analysis to determine the issues with obtaining survey responses. |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data was analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021 |
| **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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Adult 2021 |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **Absolute Total Care** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION- CHILD CCC** |
| **Validation Period** | 2021 |
| **Review Performed** | 2022 |

***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. (Updated based on October 2019 version of EQR protocol 6)

## 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:* SPH Analytics Member Satisfaction Report-Child CCC 2021 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective is documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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:* SPH Analytics Member Satisfaction Report-Child CCC 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 tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2021 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2021 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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 were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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 was reported and bias in generalizability is documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 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 was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2021 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2021 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 1,646. The total completed surveys for the general population was 158 for a 9.6% response rate. This response rate was lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate was lower than the previous year's rate of 14%.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021<br><br>**Recommendation:** Consider a barriers analysis to determine the issues with obtaining survey responses from the CCC population. |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data were analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021 |
| **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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2021 |

# CCME EQR Survey Validation Worksheet

| | |
|---|---|
| **Plan Name** | **Absolute Total Care** |
| **Survey Validated** | **CAHPS MEMBER SATISFACTION- CHILD** |
| **Validation Period** | 2021 |
| **Review Performed** | 2022 |

***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. (Updated based on October 2019 version of EQR protocol 6)

## 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:* SPH Analytics Member Satisfaction Report-Child 2021 |
| **1.2** | Review that the study objectives are clear, measurable, and in writing. | **MET** | Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2021 |
| **1.3** | Review that the intended use or audience(s) for the survey findings are identified. | **MET** | Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report-Child 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 was tested for validity. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2021 |
| **2.2** | Assess whether the survey instrument was tested for reliability and found to be reliable | **MET** | Survey was tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report-Child 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2021 |
| **3.3** | Review that the sampling method appropriate to the survey purpose | **MET** | Sampling method was conducted according to specifications.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 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 were in accordance with standards.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 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 was reported and bias in generalizability was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 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 was documented.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2021 |
| **5.2** | Did the implementation of the survey follow the planned approach? | **MET** | Survey implementation followed the plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report-Child 2021 |

| Survey Element | | Element Met / Not Met | Comments and Documentation |
|---|---|---|---|
| **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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2021 |
| **6.2** | Were appropriate statistical tests used and applied correctly? | **MET** | Appropriate tests were utilized.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2021 |
| **6.3** | Were all survey conclusions supported by the data and analysis? | **MET** | Conclusions were supported by data analysis.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 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 were in place to address response issues.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2021 |
| **7.2** | Do the survey findings have any limitations or problems with generalization of the results? | The sample size was 2,546. The total completed surveys was 240 for a 9.4% response rate. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. The rate is lower than the previous response rate of 11.8%.<br>*Documentation:* SPH Analytics Member Satisfaction report- Child 2021<br><br>**Recommendation:** Consider a barriers analysis to determine the issues with obtaining survey responses |
| **7.4** | What data analyzed according to the analysis plan laid out in the work plan? | Data were analyzed according to work plan.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2021 |
| **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.<br>*Documentation:* SPH Analytics Member Satisfaction Report- Child 2021 |

## D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

# CCME MCO Data Collection Tool

| | |
|---|---|
| **Plan Name:** | Absolute Total Care |
| **Collection Date:** | 2021 |

## 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 CC.COMP.22, Policy Management, provides guidance for the development, review, approval, and maintenance of Company policies. |
| **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: | | | | | | The ATC 2021 Organizational Chart outlines the lines of business management and department oversight. |
| 1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED)); | X | | | | | The President and CEO of ATC is John McClellan. |
| 1.2 Chief Financial Officer (CFO); | X | | | | | Stephen Moore is the Chief Financial Officer. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.3 * Contract Account Manager; | X | | | | | |
| 1.4 Information Systems Personnel; | | | | | | Crystal Freie is the Director of Marketing and Communication. |
| 1.4.1 Claims and Encounter Manager/ Administrator, | X | | | | | The Sr. Director and Supervisor of Claims Services is Cynthia Jones. |
| 1.4.2 Network Management Claims and Encounter Processing Staff, | X | | | | | The VP of Network Development is Donald Pifer. |
| 1.5 Utilization Management (Coordinator, Manager, Director); | X | | | | | The Director, Utilization Management is Natalie Crumpton. |
| 1.5.1 Pharmacy Director, | X | | | | | Jenna Meisner is the Sr. Director of Pharmacy. |
| 1.5.2 Utilization Review Staff, | X | | | | | |
| 1.5.3 *Case Management Staff, | X | | | | | Lee Jernigan is the Director of Case Management. |
| 1.6 *Quality Improvement (Coordinator, Manager, Director); | X | | | | | The Sr. VP of Quality Improvement is Joyce McElwain. |
| 1.6.1 Quality Assessment and Performance Improvement Staff, | X | | | | | |
| 1.7 *Provider Services Manager; | X | | | | | |
| 1.7.1 *Provider Services Staff, | X | | | | | |
| 1.8 *Member Services Manager; | X | | | | | |
| 1.8.1 Member Services Staff, | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.9 *Medical Director; | X | | | | | Barry Lewis is the Chief Medical Director. |
| 1.10 *Compliance Officer; | X | | | | | Don Schmadel is the Director of Ethics and Compliance. |
| 1.10.1 Program Integrity Coordinator; | X | | | | | |
| 1.10.2 Program Integrity FWA Investigative/Review Staff; | X | | | | | |
| 1.11 * Interagency Liaison; | X | | | | | |
| 1.12 Legal Staff; | X | | | | | |
| 1.13 Board Certified Psychiatrist or Psychologist; | X | | | | | Frank Shelp is ATC's Board-Certified Psychiatrist. |
| 1.14 Post-payment Review Staff. | X | | | | | |
| 2. Operational relationships of MCO staff are clearly delineated. | X | | | | | |
| **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 | | | | | Absolute Total Care's ISCA documentation states the MCO follows the established timeliness guidelines defined by SCDHHS. It also stated claims processors are audited multiple times per month (typically 10 or more times), and that the overall claims process is audit monthly. Monthly audits are reviewed by the MCO's claims processing team. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions. | X | | | | | The ISCA documentation states ATC currently accepts almost all data electronically. The average number of paper submissions is 4% or less per source. Additionally, the MCO relies on standards-compliant forms to help ensure accurate data submissions. |
| 3. The MCO tracks enrollment and demographic data and links it to the provider base. | X | | | | | ATC tracks enrollment and demographic data and links the data to its provider base. ISCA documentation states the MCO collects claim/encounter data and stores the information in its data warehouse. The data warehouse is able to link and correlate demographics, member preferences, and member attributes. |
| 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 | | | | | The MCO's management information system is sufficient to support data reporting to SCDHHS and internally for MCO quality improvement and utilization monitoring activities. Specifically, for HEDIS reporting, ATC loads all claims and member/provider data from its data warehouse into a separate performance and analysis system. This configuration allows for analysis and reporting to be performed while minimizing the impact on data warehouse resources. |
| 5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract. | X | | | | | ATC has policies, procedures, and processes in place to address data security as required by the *SCDHHS Contract*. ISCA documentation describes strong physical security practices and a layered approach to protecting data. |

| 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 | | | | | ATC has policies, procedures, processes in place to address system and information security and access management. Specifically, ATC adheres to password best practices and uses multi-factor with remote access. Finally, ATC notes that it has a device tracking system that allows it to physically locate a device when it is connected to a network. |
| 7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented. | X | | | | | ATC's IT operations are conducted in one of its two data centers. The second data center serves as a failover location if a disaster occurs. The most recent disaster recovery test was successful in recovering all services and functionality. |
| **I D. Compliance/Program Integrity** | | | | | | |
| 1. The MCO has a Compliance Plan to guard against fraud and abuse. | X | | | | | The 2021/2022 Compliance and Ethics Program Description integrates all applicable federal and state laws, regulations, accreditation standards, and contractual obligations into daily operations. The ATC Employee Handbook outlines the role of every employee to demonstrate compliance with the Fraud, Waste, and Abuse Program to prevent, detect, and report suspected or actual non-compliance. |
| 2. The Compliance Plan and/or policies and procedures address requirements, including: | X | | | | | |
| 2.1 Standards of conduct; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.2 Identification of the Compliance Officer and Program Integrity Coordinator; | | | | | | |
| 2.3 Inclusion of an organization chart identifying names and titles of all key staff; | | | | | | The 2021 Compliance Organizational Chart identifies the structure of the Compliance department led by the Compliance Officer, staff, and position titles. |
| 2.4 Information about the Compliance Committee; | | | | | | ATC's Compliance Committee meets quarterly and is chaired by the Compliance Officer. The Compliance Committee Matrix identifies the voting members. The committee includes a cross-functional team of individuals from within the organization, the Board of Directors, and other senior leadership, as needed, who have the authority to implement corrective actions. |
| 2.5 Compliance training and education; | | | | | | Compliance training programs and written publications are provided upon hire and annually, to include information on the Compliance Program, the identification and reporting of fraud, waste, and abuse, the Code of Conduct, Business Ethics and Conduct policy, HIPAA privacy, the Federal False Claims Act, and other compliance-related policies, procedures, standards. The Compliance Department communicates its standards and procedures to all employees (including senior management and temporary employees), subcontractors, the Board of Directors, and other agents. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.6 Lines of communication; | | | | | | Lines of communication are outlined clearly in the Compliance and Ethics Program Description. ATC requires its employees to report all suspected and confirmed incidents of fraud, waste, abuse, illegal acts, inappropriate disclosures, and/or other incidents that contravene applicable law, regulations, or ATC's and Centene's Business Ethics and Conduct policy.<br><br>Independent reporting paths are available for employees to report such acts, including:<br>•An Ethics and Compliance Helpline<br>•A separate Fraud, Waste, and Abuse Helpline<br><br>Both are available 24 hours a day, 7 days a week, 365-days a year and permit anonymous reporting. |
| 2.7 Enforcement and accessibility; | | | | | | |
| 2.8 Internal monitoring and auditing; | | | | | | |
| 2.9 Response to offenses and corrective action; | | | | | | Potential sanctions are outlined in policy and range from oral warnings, privilege revocation, financial penalties, or termination. |
| 2.10 Data mining, analysis, and reporting; | | | | | | Audits are conducted to ensure compliance with specific contractual requirements, applicable federal and state laws, and includes, but is not limited to, annual contract assessments, ad hoc |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | functional area audits as necessary, and monitoring of grievance and appeals activities. |
| 2.11 Exclusion status monitoring. | | | | | | |
| 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 | | | | | The Special Investigations Unit (SIU), the Payment Integrity Department, and the Compliance Department conduct investigations of suspected fraud, waste and abuse by personnel, providers, subcontractors, or members to the extent necessary to determine if reporting to the SC Medicaid Fraud Control Unit (MFCU) and/or the Office of the Inspector General (OIG) is necessary. |
| 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 | | | | | |
| **I E. Confidentiality**<br>*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 | | | | | The HIPAA-PHI Desk-Field Audit Training document clearly outlines ATC policies, desk and work area audit procedures, and step-by-step violation outcomes. Policy CC.COMP.04, |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Confidentiality and Release of Protected Health Information, is applicable to employees, officers, and directors of Centene Corporation, its affiliates, and Subsidiary Health Plans. |

## II. PROVIDER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **II. PROVIDER SERVICES** | | | | | | |
| **II A. Credentialing and Recredentialing**<br>*42 CFR § 438.214, 42 CFR § 457.1233(a)* | | | | | | |
| **1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.** | X | | | | | Requirements and processes for initial provider credentialing and recredentialing are documented in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment. |
| **2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including** | X | | | | | ATC's Credentialing Committee makes credentialing determinations using a peer-review process. As noted in Policy CC.CRED.03, Credentialing Committee, voting members of |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.** | | | | | | the committee include the Medical Director and network physician attendees, and the quorum is defined as the presence of two-thirds of the voting members. The committee meets monthly, no less than 10 times/year and reports to the QIC quarterly. The policy does not address the attendance expectations for committee members; however, the 2021 Quality Program Description-Medicaid/Marketplace states the expectation is that members attend at least 50% of the meetings.<br><br>The ATC Credentialing Committee Roster for 2021 still includes a general surgery provider who retired from the committee in February 2021 with no notation that the provider retired from committee membership.<br><br>ATC's credentialing committee includes only one network practitioner (Pediatrics) who is not a health plan employee. Other physician members are health plan employees with specialties of Anesthesiology, Surgery, and Psychiatry. The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*, states MCO Credentialing Committees should have "broad representation from all disciplines (including mid-level practitioners)." |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | CCME recommended during the previous EQR that ATC recruit an additional adult medicine provider for committee membership. ATC reported that very recently the Credentialing Committees for ATC and WellCare were merged, adding an additional adult PCP provider to the committee's membership.<br><br>The SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8, states MCO Credentialing Committees should have "broad representation from all disciplines (including mid-level practitioners)…"<br><br>*Recommendation: Ensure that the Credentialing Committee Roster is updated as members are added to or removed from the committee. Recruit additional network physicians for the Credentialing Committee to ensure broad representation from all disciplines within the network. For example, recruit a Family Practitioner, OB/GYN, etc. and a mid-level practitioner, such as a nurse practitioner or physician assistant.* |
| **3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.** | X | | | | | |
| 3.1 Verification of information on the applicant, including: | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 | | | | | One initial credentialing file was missing verification of the provider's National Provider Identifier.<br><br>*Recommendation: Ensure initial credentialing files for all providers include evidence of verification of the provider's National Provider Identifier.* |
| 3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility; | X | | | | | |
| 3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 3.2 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 | | | | | |
| 4.1 Recredentialing conducted at least every 36 months; | X | | | | | |
| 4.2 Verification of information on the applicant, including: | | | | | | |
| 4.2.1 Current valid license to practice in each state where the practitioner will treat members; | X | | | | | |
| 4.2.2 Valid DEA certificate and/or CDS certificate; | X | | | | | |
| 4.2.3 Board certification if claimed by the applicant; | X | | | | | |
| 4.2.4 Malpractice claims since the previous credentialing event; | X | | | | | |
| 4.2.5 Practitioner attestation statement; | X | | | | | |
| 4.2.6 Requery the National Practitioner Data Bank (NPDB); | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 4.2.7 Requery of System for Award Management (SAM); | X | | | | | |
| 4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline); | X | | | | | |
| 4.2.9 Requery of the State Excluded Provider's Report 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 | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 | | | | | Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, addresses processes and requirements for provider disciplinary action, up to and including termination. The policy describes steps taken to investigate providers, refer to the Peer Review Committee and Credentialing Committee, and make a final decision to terminate or otherwise sanction a provider. Policy CC.PRVR.23, Provider Termination Policy, describes processes and requirements for provider termination when requested by the provider and when initiated by the health plan. |
| 6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities. | X | | | | | Processes and requirements for organizational provider credentialing and recredentialing are specified in Policy CC.CRED.09, Organizational Assessment and Reassessment. No deficiencies were noted in the organizational provider credentialing and recredentialing files reviewed. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds. | X | | | | | The Credentialing department conducts ongoing monthly monitoring of the Medicare/Medicaid-specific exclusions or NPDB reports, OIG LEIE, licensing boards, SAM, state specific exclusions, etc. Detailed information about this monitoring process is found in Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints. Ongoing monitoring also includes complaints and quality issues that could impact a practitioner's ability to provide safe, appropriate care to members. |
| **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 CC.PRVR.47, Evaluation of Practitioner Availability, defines access standards for PCPs as one provider within 30 miles or 45 minutes.<br><br>The Quality Assessment and Performance Improvement Program Evaluation Medicaid and Marketplace - 2020 states ATC's goal is that 90% of members have at least one PCP within 30 miles or 45 minutes of the member's home and indicates that the goal was met for all PCP types (Family/General Practitioners, Internal Medicine and Pediatrics) for 2020. The Quality |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Improvement Committee Meeting Minutes from 6/29/21 included review and approval of the Practitioner Availability Report. |
| 1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty. | X | | | | | Policy CC.PRVR.47, Evaluation of Practitioner Availability, defines access standards for specialists as one provider within 50 miles and 75 minutes. The Quality Assessment and Performance Improvement Program Evaluation Medicaid and Marketplace - 2020 states ATC's goals were met for total number and geographic distribution for high-volume and high-impact specialists in 2020. |
| 1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually. | | X | | | | As stated in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC measures practitioner type and availability annually. Also included in the assessment of the network are survey results and grievance data regarding satisfaction with practitioner availability. Results are reported and reviewed by the Quality Committee which makes recommendations to address any identified deficiencies.<br><br>The Geo Access mapping dated November 10, 2021, did not include results for all SCDHHS-designated Status 1 provider types as it did not include Pediatrics practitioners. This is a repeat finding from the previous EQR. This finding was discussed with ATC staff during the onsite, and |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | additional information was provided that "when GEO Access Reports were generated, Pediatrics was inadvertently omitted from the report."<br><br>*Quality Improvement Plan: Ensure evaluation of network adequacy includes measuring access for all SCDHHS-designated Status 1 providers. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 6.2.* |
| 1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs. | X | | | | | To ensure the provider network can meet the needs of its membership, ATC conducts annual assessments of the cultural, ethnic, racial, and linguistic needs of members. Providers' cultural, ethnic, racial, and/or linguistic data are collected through the credentialing process. Interventions are implemented as necessary and may include recruiting practitioners who speak alternate languages and/or with diverse cultural or ethnic backgrounds. ATC may also require practitioners to complete cultural competency training courses based on the racial/ethnic composition of member population.<br><br>Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), describes processes to gather and assess member and provider cultural, ethnic, racial, and/or |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | linguistic data and to develop an annual Cultural Competency Work Plan. Processes are in place to provide language assistance, including qualified interpreter services, video relay and TTY communication services, sign language services, bilingual staff, etc.<br><br>ATC's Provider Manual includes a Cultural Competency Overview and informs providers of their responsibilities related to culturally competent care for members. Providers are directed to the plan website or to contact Provider Services for more information.<br><br>The ATC website includes the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide; however, the documents are listed under the heading of "Medicare-Medicaid Plan (MMP) Education and Training" on the "Provider Training" page and there is no heading for Medicaid Education and Training.<br><br>*Recommendation: Include the Cultural Competency Quick Reference Guide and Americans with Disabilities Act (ADA) - Disability Awareness Training Quick Reference Guide in an area of the website specific to* |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | *Medicaid providers or move them to a general provider education section.* |
| 1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand. | X | | | | | The ATC Network Strategy Overview January 2022 document states that for ATC's Medicaid network, the plan is focusing on adding depth to specialists and ensuring PCP wait times are within established standards. ATC will focus contracting efforts on free-standing ambulatory surgery centers to offer members greater access at a lower cost. |
| 2. The MCO maintains a provider directory that includes all requirements. | X | | | | | Policy CC.PRVR.19, Provider Directory – Portico, states ATC maintains a searchable, web-based Provider Directory that includes all physicians, hospitals, and others with whom ATC holds contracts. The policy lists elements that must be included in the Provider Directory; however, the policy does not specify "age groups," as required by the *SCDHHS Contract, Section 3.13.5.1.1.* CCME confirmed the ATC Provider Directory includes age groups where applicable.<br><br>*Recommendation: Update CC.PRVR.19, Provider Directory – Portico, to indicate "age groups" is a required element of the Provider Directory.* |
| 3.Practitioner Accessibility<br>*42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 CC.PRVR.48, Evaluation of the Accessibility of Services, describes processes to monitor member access to primary care, behavioral health, and specialty care services annually. Results are analyzed by the Quality Committee and recommendations are made to address deficiencies.<br><br>The policy does not define the specific appointment access standards followed. It is noted that this policy covers multiple lines of business; however, similar policies had attachments with the specific information for each state and/or line of business. The Provider Manual and Member Handbook are the only documents in which the South Carolina Medicaid appointment access standards were found.<br><br>*Recommendation: Update Policy CC.PRVR.48, Evaluation of the Accessibility of Services, to include an attachment with the South Carolina Medicaid appointment access standards or create a South Carolina-specific policy to include this information.* |
| 3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results. | | | X | | | As part of the annual EQR process for ATC, a provider access study was conducted focusing on primary care providers. A list of current providers was given to CCME by ATC, from which a population of 2,268 unique PCPs was |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | found. A sample of 178 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.<br><br>For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 61% of the time (96 out of 157) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's result of 73%, this year's study had a decrease in successful calls at 61% (p=.0257), representing a statistically-significant decrease of 12%.<br><br>For calls not answered successfully (n = 61 calls), 24 (39%) were because the provider was no longer an active PCP at the location. For the question, "Do you accept Absolute Total Care?" 84 of 96 providers (88%) said that they do accept ATC. Of those 84, 59 (70%) providers were accepting new Medicaid patients; 45 out of those 59 (76%) indicated they do have prescreening requirements. Of those 14 providers with prescreen requirements, five (36%) required an application, seven (50%) required a medical record review, one (7%) |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | required both, and one (7%) required vaccine records.<br><br>*Quality Improvement Plan: Determine additional methods to maintain updated information, such as current provider practice locations, in provider files. Increase E-Verify usage to more than four times per year to increase accuracy of provider files.* |
| **II C. Provider Education**<br>*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 | | | | | Policy SC.PRVR.13, Provider Orientations, states newly-contracted providers who are not part of an existing participating group/facility receive an orientation to provide necessary information and materials to understand health plan requirements and processes. Provider orientations are conducted within 30 business days of becoming active with ATC.<br><br>The "Medicaid Orientation December 2020" document includes an overview of Centene, provider responsibilities, and information about member eligibility, utilization management processes and requirements, claims, the website, the provider portal, etc. The Provider Manual, available on the ATC website, is also a resource for providers. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. Initial provider education includes: | | | | | | |
| 2.1 MCO structure and health care programs; | X | | | | | |
| 2.2 Billing and reimbursement practices; | X | | | | | |
| 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS; | X | | | | | |
| 2.4 Procedure for referral to a specialist; | X | | | | | |
| 2.5 Accessibility standards, including 24/7 access; | X | | | | | |
| 2.6 Recommended standards of care; | X | | | | | |
| 2.7 Medical record handling, availability, retention and confidentiality; | X | | | | | |
| 2.8 Provider and member grievance and appeal procedures; | X | | | | | |
| 2.9 Pharmacy policies and procedures necessary for making informed prescription choices; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.10 Reassignment of a member to another PCP; | X | | | | | |
| 2.11 Medical record documentation requirements. | X | | | | | |
| 3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures. | X | | | | | As noted in Policy SC.PRVR.14, Provider Visit Schedule/On-going Education, Provider/Network Relations Specialists hold regular meetings with participating providers. In addition, virtual and/or in-person provider training sessions are held in at least four regional locations throughout the state annually. ATC reported all provider education activities are conducted virtually, due to the current pandemic, and that the virtual sessions have been well-attended. |
| **II D. Primary and Secondary Preventive Health Guidelines**<br>*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 | | | | | ATC adopts preventive health guidelines (PHGs) from recognized sources that are relevant to health needs of the member population and/or opportunities for improvement identified through the Quality Program. The Quality Improvement Committee (QIC), which includes physician representation, reviews and approves the PHGs for adoption. The guidelines are reviewed at least every two years and revised |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | when there is significant new scientific evidence or changes in national standards. Processes for adoption and ongoing review are detailed in Policy SC.QI.08, Clinical and Preventive Practice Guidelines. Review of the QIC minutes for March 30, 2021, confirmed review, discussion, and approval of the PHGs. |
| 2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers. | X | | | | | As noted in Policy SC.QI.08, mechanisms to distribute the guidelines include the ATC website, provider orientation materials, mailings, newsletters, and fax blasts. The Provider Manual includes a list of adopted guidelines and directs the reader to the website to review the guidelines. Providers may also request printed copies by contacting the health plan.<br><br>The Provider Manual informs that providers are encouraged to use the PHGs, and that ATC may measure compliance through monitoring of HEDIS measures and random medical record audits. |
| 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 | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 | | | | | |
| **II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services**<br>*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 | | | | | ATC adopts clinical practice guidelines (CPGs) that are relevant to the member population for at least two non-preventive acute or chronic medical conditions and at least two behavioral health conditions (preventive or non-preventive) from recognized sources. The QIC reviews and approves the CPGs for adoption.<br><br>Policy SC.QI.08, Clinical and Preventive Practice Guidelines, the Provider Manual, and the QI |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Program Description indicate the guidelines are reviewed every two years. However, the QIC minutes for March 30, 2021, indicate the guidelines are reviewed at least annually.<br><br>*Recommendation: Revise Policy SC.QI.08, the Provider Manual, and the QI Program Description to state clinical practice guidelines are reviewed annually.* |
| 2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers. | X | | | | | As noted in the policy, mechanisms to distribute the guidelines include the ATC website, new practitioner orientation materials, provider newsletters, special mailings, and fax blasts. The Provider Manual includes a list of adopted guidelines and directs the reader to the website to review the guidelines. Providers may also request printed copies by contacting the health plan.<br><br>Providers are encouraged to use the CPGs, and informed that ATC may measure compliance through monitoring of HEDIS measures and random medical record audits. |
| **II F. Continuity of Care**<br>*42 CFR § 438.208, 42 CFR § 457.1230(c)* | | | | | | |
| 1. The MCO monitors continuity and coordination of care between PCPs and other providers. | X | | | | | Policy CC.QI.09, Continuity & Coordination of Medical Care, and Policy CC.QI.10, Continuity & Coordination Between Medical and Behavioral Health Care, describe ATC's processes for |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | monitoring continuity and coordination of care between PCPs and other providers, as well as when members move across care settings. ATC collects data to assess, identify opportunities, and act on opportunities to improve coordination of care. A summary and analysis are presented to the QIC and included in the annual Quality Program Evaluation.<br><br>The 2020 QI Program Evaluation listed areas monitored for medical and behavioral health to assess coordination of care. The evaluations included assessments of the effectiveness of interventions, and documentation of barriers, opportunities for improvement, and action plans for each of the areas monitored, and were reported to the QIC in May 2021 (behavioral health) and June 2021 (medical). |
| **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 | | | | | Medical record documentation standards are found in Attachment A of Policy SC.QI.13, Medical Record Review, on the Medical Record Documentation Standards form on ATC's website, and in the Provider Manual. All required elements are included. |
| 2. Standards for acceptable documentation in member medical records are consistent with contract requirements. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 Provider Manual informs providers of their responsibility to maintain accurate and complete medical records as well as to maintain member confidentiality. Information is also available on the ATC website.<br><br>Processes for conducting medical record audits are detailed in Policy SC.QI.13, Medical Record Review. ATC conducts annual medical record documentation audits for selected PCPs and may include high volume specialists (i.e. OB/GYN). An aggregate summary of the medical record audit is reported to the QIC annually and results are trended to determine plan-wide opportunities for improvement. Issues may be addressed via network-wide and/or provider-specific education to improve elements of medical record documentation. Results are shared with the Credentialing Department for consideration at recredentialing.<br><br>The Medicaid Medical Record Review 2021 Annual Audit Report indicates all audited providers received passing scores. The overall score (96.4%) demonstrated an increase over the previous year's score of 95%. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract. | X | | | | | |

## III. MEMBER SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **III. MEMBER SERVICES** | | | | | | |
| **III A. Member Rights and Responsibilities**<br>*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 | | | | | Policy SC.MBRS.25, Member Rights and Responsibilities, defines how ATC advises members of their rights and responsibilities and how these rights are protected. Members receive a Member Welcome Packet upon enrollment into the plan detailing their rights and responsibilities. The Member Handbook and |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | website also describes member rights and responsibilities. |
| 2. Member rights include, but are not limited to, the right: | X | | | | | Policy SC.MBRS.25, Member Rights and Responsibilities, describes member rights and responsibilities. |
| 2.1 To be treated with respect and with due consideration for dignity and privacy; | | | | | | |
| 2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand; | | | | | | |
| 2.3 To participate in decision-making regarding their health care, including the right to refuse treatment; | | | | | | |
| 2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations; | | | | | | |
| 2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*); | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member. | | | | | | |
| **III B. Member MCO Program Education** *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 | | | | | |
| 1.1 Benefits and services included and excluded in coverage; | | | | | | |
| 1.1.1 Direct access for female members to a women's health specialist in addition to a PCP; | | | | | | |
| 1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary. | | | | | | |
| 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; | | | | | | Copayments and limits of coverage are listed in the Member Handbook and on the website. Copayments are not required for services for |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | children under 19 years of age, pregnant woman, and institutionalized individuals. |
| 1.4 Any requirements for prior approval of medical or behavioral health care and services; | | | | | | Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual. Prior approval is not required for family planning services, emergency visits, or behavioral health services. |
| 1.5 Procedures for and restrictions on obtaining out-of-network medical care; | | | | | | |
| 1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services; | | | | | | The nurse advice line is available for health questions 24 hours a day, seven days a week. Medical advice for children and adults, health information, assistance in determining where to go for care, answers to personal health questions, and information about pregnancy are all topics available by calling the nurse advice line. |
| 1.7 Policies and procedures for accessing specialty care; | | | | | | |
| 1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions; | | | | | | The Member Handbook and website indicate that durable medical equipment including is covered and may require prior authorization in some instances. |
| 1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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; | | | | | | |
| 1.14 Instructions on how to request interpretation and translation services at no cost to the member; | | | | | | |
| 1.15 Member's rights, responsibilities, and protections; | | | | | | |
| 1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them; | | | | | | |
| 1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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; | | | | | | Policy SC.QI.25, Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description describes ATCs work to ensure that members, through the month of their 21st birthday, receive comprehensive and preventive health care and services based upon adopted practice guidelines. |
| 1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive; | | | | | | The Member Handbook and website provides information about the definition, types, and options for obtaining advice for completing advanced directives. Information is provided about points of contact for assistance if member's directives are not followed. |
| 1.21 Information on how to report suspected fraud or abuse; | | | | | | Fraud and abuse are defined in the Member Handbook and on the website. Examples are provided. Instructions are provided for members to anonymously report fraud and abuse to ATC, SCDHHS, and to South Carolina's Division of Program Integrity. |
| 1.22 Additional information as required by the contract and/or federal regulation; | | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 | | | | | Policy SC.COMM.15, Request, Preparation, and Approval Process for Marketing and Communication Materials, and Policy SC.COMM.19, Member Materials Readability, describe processes to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. |
| 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 | | | | | A Member Services Call Center and 24-Hour Nurse Line is available to members. Additionally, the 24-Hour Nurse Advice Line is staffed with mental health professionals who can address the member's urgent behavioral health needs. The TTY:711 relay is communicated in several member materials and on the website. |
| **III C. Member Enrollment and Disenrollment** *42 CFR § 438.56* | | | | | | |
| 1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed. | X | | | | | |
| 2. MCO-initiated member disenrollment requests are compliant with contractual requirements. | X | | | | | Information on member disenrollment is provided in Policy SC.ELIG.10, Member Disenrollment, the |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Member Handbook, and on the website. All Member requests for disenrollment are referred to SCDHHS or its designee. The effective date of an approved disenrollment request must be no later than the first day of the second month following the month in which the Medicaid Member filed the request. |
| **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 | | | | | ATC contracts with SPH Analytics, a certified CAHPS survey vendor, to conduct the adult and child surveys.<br><br>*Recommendation: Continue conducting a barriers analysis to determine the issues with obtaining survey responses as response rates have decline over the past three survey cycles.* |
| 1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership; | X | | | | | SPH analytics summarizes and details all results from Child, Child CCC, and Adult surveys. |
| 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 | | | | | |
| 3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey. | X | | | | | |
| 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 | | | | | |
| **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 | | | | | Information about grievances processes and requirements is found in Policy SC.MM.11, Member Grievances, the UM Program Description, Member Handbook, Provider Manual, and on the ATC website. |
| 1.1 The definition of a grievance and who may file a grievance; | X | | | | | |
| 1.2 Procedures for filing and handling a grievance; | X | | | | | |
| 1.3 Timeliness guidelines for resolution of a grievance; | X | | | | | Grievances are resolved within 90 calendar days of receipt. Timeliness guidelines for grievance resolution are correctly documented in Policy SC.MM.11, Member Grievances, the Member Handbook, and the Provider Manual. |
| 1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee; | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract. | X | | | | | Policy SC.MM.11, Member Grievances, indicates that grievance records are accurately maintained in a manner accessible to the state and available upon request to CMS. A copy of grievance logs and records of resolution of grievances shall be retained in accordance with the provisions of the *S.C. Code Ann. § 38-33-110(A) (2),* for a period of no less than 10 years. |
| 2. The MCO applies grievance policies and procedures as formulated. | X | | | | | |
| 3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Policy SC.MM.11, Member Grievances, explains all member grievances are reviewed by the Quality Improvement Department to identify trends and opportunities for improvement. ATC tracks and monitors member grievance data quarterly. Results and analysis are presented and discussed during QIC meetings and reflected in committee minutes. |
| 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 | | | | | The 2021 Quality Program Description – Medicaid/Marketplace was submitted for review. The scope of work described in the program description includes areas such as preventive health, acute and chronic care, over and underutilization, population health management, behavioral health, continuity and coordination of care, accessibility and availability of care, member services, patient safety, HEDIS and CAHPS results, provider satisfaction and health outcomes. On an annual basis, the Quality Department reviews the Quality Program Description and makes revisions as needed.<br><br>Annually, ATC makes information about its Quality Program available to members and practitioners. ATC's website contained several resources explaining the Quality Program and directions for calling with additional questions. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 | | | | | |
| 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 | | | | | ATC develops an annual work plan to direct the planned activities for improving the quality and safety of clinical care and services. ATC presented the 2020 and 2021 QI Work Plans for review. Both are reviewed and updated at least quarterly. The work plans included the standard/scope, objective, a description of activities, responsible person(s), timeline/frequency, and each activity's status. ATC also addressed previously identified issues and opportunities.<br><br>The objective for the delegation section of the work plan (page 26) mentions "ATC will maintain oversight of all functions performed by delegated entities." The Delegation activities listed on page 26 of the 2021 Work Plan only included the oversight for NIA and Envolve Benefit Options, Envolve People Care, and Envolve Pharmacy Solutions. Delegation for the credentialing activities is not included. Also, the annual NIA audit was the only activity listed as completed.<br><br>*Recommendation: Include the oversight monitoring of all functions performed by a delegated entity in the QI Work Plan.* |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **IV B. Quality Improvement Committee** | | | | | | |
| 1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities. | X | | | | | ATC's Quality Improvement Committee (QIC) is the senior management committee accountable to the Board of Directors. The QIC provides oversight and direction in assessing the appropriateness of care and service delivery. Each internal department participates and contributes to the Program and works collaboratively on QI activities.<br><br>The QI Program Description outlines ATC's committee structure and committee charters for the QIC and other subcommittees. |
| 2. The composition of the QI Committee reflects the membership required by the contract. | X | | | | | The QIC is chaired by the Chief Medical Officer. Other members include senior management staff, network practitioners, and other support staff. All senior staff and network physicians are considered voting members. Three voting members including the Senior Quality Improvement Executive, one ATC staff, and one external practitioner must be present for a quorum. |
| 3. The QI Committee meets at regular quarterly intervals. | X | | | | | Copies of the committee minutes provided by ATC demonstrated the committees met at quarterly intervals. |
| 4. Minutes are maintained that document proceedings of the QI Committee. | X | | | | | Detailed records and minutes for all meetings are maintained. The committee minutes were complete, signed, and dated by the recorder and the chair. Meeting minutes are reviewed and approved at the next meeting of the committee. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **IV C. Performance Measures**<br>*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 | | | | | ATC uses a certified software organization for calculation of HEDIS rates and met all the validation requirements. The comparison from the previous to the current year revealed a strong increase (>10%) in several rates, including 7-day follow-up after ED visit for mental illness for 6–17 year-olds, Opioid abuse Initiation and Engagement of AOD treatment for 18+ year-olds. There were also a few measures that had a substantial decline (>10%) including:<br>•BMI percentile documentation<br>Counseling for nutrition and physical activity in children/adolescents<br>•Appropriate testing for pharyngitis<br>•Asthma medication ratio for 19-50 and 51-64 year olds<br>•Persistence of beta blocker after a heart attack<br>•Eye exam for diabetes |
| **IV D. Quality Improvement Projects**<br>*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 this review, three PIPs were submitted. Topics for PIPs include Postpartum Care, Provider Satisfaction, and Hospital Readmissions. The Postpartum Care PIP was retired and not included in this validation. |
| 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. The reported rates for the provider satisfaction and readmission PIP showed improvements in the rates and interventions were effective. Details of the validation of the performance improvement |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | projects can be found in the *CCME EQR Validation Worksheets, Attachment 3.* |
| **IV E. Provider Participation in Quality Improvement Activities** | | | | | | |
| 1. The MCO requires its providers to actively participate in QI activities. | X | | | | | |
| 2. Providers receive interpretation of their QI performance data and feedback regarding QI activities. | X | | | | | ATC profiles the quality of care delivered by high-volume PCPs to improve compliance with practice guidelines and clinical performance indicators.<br><br>Per the QI Program Description, "ATC offers a quality, cost and utilization tool designed to support providers who participate in a value-based program in order to identify provider performance opportunities and assist with population health management initiatives." Provider analytics prioritizes measures based on providers' performance to help identify where to focus clinical efforts."<br><br>Provider report cards that focus on pediatric measures are sent to network providers annually. ATC did not send provider reports cards due to the changes in the well child measures for HEDIS measure year 2020 and true benchmarks not being available. Providers were notified of this change and rates were made available on ATC's website. |

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **IV F. Annual Evaluation of the Quality Improvement Program**<br>*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 | | | | | ATC evaluated the effectiveness of the QI program and activities conducted in 2020 and provided CCME with a copy of this formal evaluation. The 2020 Quality Program Evaluation included a summary and results for each quality activity, any barriers identified and opportunities for improvement. The program evaluation findings and recommendations are used in developing the upcoming year's annual QI Program Description and Work Plan.<br><br>The Delegated Vendor Oversight section (page 43) appeared incomplete. The oversight for Envolve Benefit Options, Envolve People Care, and Envolve Pharmacy Solutions was not included in the results. Also, only the credentialing oversight for NIA was reported.<br><br>*Recommendation: Include the results of the oversight monitoring of all functions performed by a delegated entity in the QI Program Evaluation.* |
| 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 | | | | | ATC provided the Utilization Management Program Description 2021 for review. This program description describes the UM program structure, goals, staff roles and responsibilities, and review processes. |
| 1.1 structure of the program and methodology used to evaluate the medical necessity; | X | | | | | |
| 1.2 lines of responsibility and accountability; | X | | | | | |
| 1.3 guidelines / standards to be used in making utilization management decisions; | X | | | | | |
| 1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification; | X | | | | | |
| 1.5 consideration of new technology; | X | | | | | Centene's Corporate Clinical Policy Committee is responsible for evaluating new technologies or new applications of existing technologies. Practitioners are notified in writing of new technology determinations made by ATC. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services; | X | | | | | |
| 1.7 the mechanism to provide for a preferred provider program. | X | | | | | Per Policy SC.UM.54, Preferred Provider Designation, ATC allows a provider and/or institution recognized for consistently managing care based on quality and practice guidelines to become eligible for Preferred Provider Designation. This designation allows for the provider to be exempt from prior authorizations; or eligible for expedited prior authorization processing; or eligible for simplified/minimal documentation in their submission of prior authorization requests. The preferred provider status designation is reviewed annually. There are currently four providers designated as a preferred provider. |
| 2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee. | X | | | | | The UM Program Description describes the Chief Medical Director's role and responsibilities.<br><br>The Chief Medical Director oversees all aspects of the UM Program. A Medical Director with a specialty in Psychiatry oversees activities related to behavioral health. A registered pharmacist oversees the implementation, monitoring, and directing of pharmacy services. |
| 3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and | X | | | | | The UM program is evaluated at least annually, and modifications are made as needed. The 2020 Utilization Management Program Evaluation-Medicaid was provided. The evaluation provided an overview of |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| grievances and/or appeals related to medical necessity and coverage decisions. | | | | | | the 2020 UM program effectiveness and addressed opportunities for improvement. |
| **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 | | | | | ATC uses McKesson's InterQual guidelines to determine medical necessity and appropriateness of physical health care. For substance use disorder related care, ATC uses the American Society of Addiction Medicine criteria.<br><br>On an annual basis, an overview of the criteria is presented to the Utilization Management Committee for approval. The overview includes discussion of key changes as well as any process changes. Staff are updated related to any changes in the criteria set as needed based on when changes occur.<br><br>Providers are notified through provider orientation, the Provider Manual, health plan website, and provider newsletters of the criteria utilized for medical necessity determinations. Treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting ATC or may discuss the UM decision with the Medical Director. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. Utilization management decisions are made using predetermined standards/criteria and all available medical information. | X | | | | | UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination. |
| 3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations. | X | | | | | Policy SC.UM.45, Sterilization and Hysterectomies, addresses the requirements for sterilizations and hysterectomies, and Policy SC.UM.33, Abortions, addresses the requirements for abortions. Providers are instructed via the Provider Manual of the requirements and required consent forms can be found on ATC's website. |
| 4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions. | X | | | | | Policy CC.UM.02, Clinical Decision Criteria and Application, indicates individual member needs and characteristics at the time of the request including age, co-morbidities, complications, progress of treatment, psychosocial situation, and home environment, when applicable are considered when making clinical decisions. |
| 5. Utilization management standards/criteria are consistently applied to all members across all reviewers. | X | | | | | ATC's Interrater Reliability (IRR) process is discussed in Work Process, CC.UM.02.05, Interrater Reliability – Associates, Medical Directors, and Therapists. UM staff, Medical Directors and Therapists participate in IRR at least annually. A score of less than 90% is considered failure and requires a corrective action plan to be implemented. The 2020 results were presented in the UM Program Evaluation and showed the overall test result for 2020 was 97%. There were no individuals that did not successfully pass. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 6. Pharmacy Requirements | | | | | | |
| 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts. | | X | | | | Policy CC.PHAR.10, Preferred Drug List, describes ATC's policy for maintaining the Preferred Drug List and identifying pharmaceutical management controls to ensure appropriate use of the health plan's pharmacy benefit. The Preferred Drug List provides formulary restrictions and indicates medications requiring prior authorization, limitations, or step therapy. Processes for members to obtain over-the-counter medications are described in the Member Handbook.<br><br>Per Policy CC.PHAR.10, Preferred Drug List, negative PDL changes are communicated to affected members and their prescribing practitioners at least 30 days in advance via the health plan website. However, some of the issues identified with this notification included:<br>•The Pharmacy and Therapeutics (P&T) Committee met and approved the PDL changes after the effective date of the change. For example, 2nd quarter 2020 changes had an effective date of March 1, 2020. The changes were discussed at the P&T Committee meeting held on March 7, 2020.<br>•1st quarter 2021 changes had an effective date of February 1, 2021. These changes were discussed at the P&T Committee meeting on January 12, 2021, which only gave a 20-day notice. Also, there were |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | PDL changes discussed during the meeting and not included on the website notice.<br>•Several changes noted in the 1st quarter 2021 P&T Committee meeting minutes (meeting date January 12, 2021) had an effective date of December 1, 2020; however, no notice was found on the website (Procysbi and Rukobia). Semglee was discussed during the January 12, 2021, P&T meeting and posted on the website; however, the effective date was January 1, 2021, which was before the committee met.<br><br>*Quality Improvement Plan: Address in a policy or desk procedure the process for ensuring negative PDL changes are published on the website at least 30 days prior to implementation as required by SCDHHS Contract, Section 4.2.21.2.3. Ensure members and their prescribing practitioners are notified at least 30 days in advance of negative PDL changes via the health plan website. Consider including the date the notices are published on the website.* |
| 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 | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 8. Utilization management standards/criteria are available to providers. | X | | | | | Providers are notified through provider orientation, the provider manual, health plan website, and provider newsletters of the criteria utilized for medical necessity determinations. |
| 9. Utilization management decisions are made by appropriately trained reviewers. | X | | | | | Per Policy CC.UM.04, Appropriate UM Professionals, a licensed health care professional conducts Level I reviews for medical necessity. A physician or other appropriate licensed health care professional reviews all requests that don't meet the UM criteria. Referral Specialists are non-licensed staff responsible for reviewing service requests for completeness of information, collecting demographic data necessary for pre-certification, and authorizing referrals to specialty providers. Referral Specialists cannot make clinical determinations and are required to refer all clinical decisions to a licensed health care professional. |
| 10. Initial utilization decisions are made promptly after all necessary information is received. | X | | | | | |
| **11. Denials** | | | | | | |
| 11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist. | X | | | | | Per *42 CFR 438.210 (b) (iii)* and the *SCDHHS Contract, Section 8.5.2.3*, any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested is made by a Health Care Professional who has appropriate clinical expertise in treating the Member's condition or disease.<br><br>Overall, the denial decisions were made by appropriate physician specialists. However, there were four cases that were questionable. For example, a pediatrician reviewed and denied an epidural steroid injection for an adult, and genetic testing was reviewed by a general surgeon and internal medicine physician. ATC explained the physician reviewers have access to consult with other physician specialties within Centene and through Advance Medical Reviews.<br><br>*Recommendation: Re-educate physician reviewers regarding the option to consult with other physician specialties within Centene and through Advance Medical Review when making denial decisions outside of their expertise. Also, document this consultation in the file.* |
| 11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the | X | | | | | UM denial files reflected timely decisions and notifications. The Adverse Benefit Determination letters were written in appropriate language for ease of member understanding, contained the rationale for |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| denial of service and the procedure for appeal. | | | | | | the denial along with references to the criteria used, and supplied information on how to request an appeal. |
| **V C. Appeals**<br>*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.UM.13, Member Appeals, describes ATC's process for resolving member disputes and responding to member appeal requests. Information on appeals processes is also found in the Member Handbook and Provider Manual. |
| 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 | | | | | |
| 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 | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 1.5 Timeliness guidelines for resolution of the appeal as specified in the contract; | X | | | | | ATC resolves and provides resolution within 30 calendar days of receipt for standard appeals and within 72 hours of receipt for expedited appeals, as noted in Policy SC.MM.13, Member Appeals. If a request for expedited appeal is denied, the member is notified, and the appeal is processed within the standard 30-day timeframe. |
| 1.6 Written notice of the appeal resolution as required by the contract; | X | | | | | ATC provided copies of the letter templates used for appeal requests. One letter template (MbrNegResLtr-A), provided to the member when ATC cannot process the appeal request, does not provide the member with their right to file a State Fair Hearing. The letter sent to members when an oral request for an appeal is made (MbrOralReqFormSC) incorrectly mentions a written appeal request must be received following receipt of an oral appeal request. According to staff, these letters are rarely used and agreed with the changes.<br><br>*Recommendation: Review and update the appeal letter templates to ensure the letter includes the member's right to fila a State Fair Hearing. Also, remove any references that require a member to submit the appeal in writing following an oral request.* |
| 1.7 Other requirements as specified in the contract. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 2. The MCO applies the appeal policies and procedures as formulated. | X | | | | | Appeal files reflected acknowledgments and resolutions were completed timely.<br><br>Policy SC.MM.13, Member Appeals, states "appeal decisions and requests to expedite an appeal decision will be made by a physician or other appropriate clinical peer of a same-or-similar specialty…" However, some of the appeal files reviewed did not meet this requirement. There were three files where the physician who made the appeal decision was not of a same or similar specialty. Two of those cases were orthopedic cases reviewed by a physician who specializes in internal medicine and the denials were overturned. One case was an orthopedic case for a pediatric member. This case was reviewed by a physician who specializes in internal/geriatric medicine.<br><br>*Recommendation: For appeal decisions, ensure the physician making the appeal decision has the same-or-similar specialty as the requesting physician.* |
| 3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee. | X | | | | | Records of all appeals are monitored quarterly and presented to the UM committee. A review of the UM committee minutes found appeals were presented during the committee meetings and areas of concern noted. |
| 4. Appeals are managed in accordance with the MCO confidentiality policies and procedures. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **V. D Care Management and Coordination**<br>*42 CFR § 208, 42 CFR § 457.1230 (c)* | | | | | | |
| 1. The MCO formulates policies and procedures that describe its care management/care coordination programs. | X | | | | | ATC's 2021 Care Management Program Description includes the program's purpose, scope, and infrastructure. Also included is information about member identification, initial screening, and ongoing assessments and management.<br><br>The Population Health Management Strategy Guide: 2021 describes the Population Health Management (PHM) Program and provides information about program goals and priorities, member programs and services, population identification and assessment, etc.<br><br>Policies and procedures provide additional detail about Care Management (CM) processes and requirements. |
| 2. The MCO has processes to identify members who may benefit from care management. | X | | | | | Procedures for identifying potential candidates for CM are documented in Policy CC.CM.02, Care Coordination/Care Management Services, and include:<br>•Health screenings completed by members<br>•Direct referrals from internal staff (UM, Member Connections, Community Health Services)<br>•Delegate/vendor/sister organization staff (nurse advice line, disease management, etc.)<br>•Members and/or caregivers |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | •Providers, hospital staff, and community/social service agencies<br>•CM and clinical program reports (enrollment reports, Notification of Pregnancy forms, etc.) |
| 3. The MCO provides care management activities based on the member's risk stratification. | X | | | | | As noted in Policy CC.CM.02, members are assessed using a health screening tool to clarify needs and determine the appropriate preliminary level of CM and the timing of the next contact. Members are stratified into the following risk levels: High Priority, Moderate Priority, and Low Priority. Members classified as children or adults with special health care needs are assigned to the Complex Care Management level. |
| 4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members. | X | | | | | ATC's Care Management Program is based on evidence-based guidelines and uses the Case Management Society of America (CMSA) Standards of Practice for Case Management. The program follows the concepts, theory, and skills for Person Centered Practices as defined by Center for Medicare and Medicaid Services, National Quality Forum and The Learning Community for Person Centered Practices. CM staff are trained in person-centered thinking and motivational interviewing to guide member goal identification and actions.<br><br>An integrated care management model is used, and members are assigned a single point of contact, such as a primary Care Manager. The primary Care |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | Manager is supported by a multidisciplinary Care Team which may include Medical Directors, licensed Social Workers, other licensed medical or behavioral health professionals, Program Coordinators, Member Connections Representatives, and Community Health Services Representatives.<br><br>Information about Targeted Case Management Services was found on page 83 of the 2020 QI Program Evaluation but not in any of the Care Management policies.<br><br>*Recommendation: Include information about Targeted Case Management Services in an appropriate CM policy or program description.* |
| 5. Care Transitions activities include all contractually required components. | | | | | | |
| 5.1 The MCO has developed and implemented policies and procedures that address transition of care. | X | | | | | Policy SC.UM.41, Transition of Care, and Policy CC.UM.20, Continuity and Coordination of Services, describe requirements and processes for managing care transitions. |
| 5.2 The MCO has a designated Transition Coordinator who meets contract requirements. | X | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 6. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary. | X | | | | | ATC conducts annual surveys to allow members who have been enrolled in Care Management to give feedback about the program. An annual evaluation of the Care Management Program is conducted, considering results of the Population Health Management population assessment and member experience surveys, data for complaints and grievances about the CM Program, practitioner complaints and satisfaction survey results, health outcomes data, and other key performance indicators.<br><br>The Population Health Management Impact Annual Report: 2020 indicates that for 2020 the goal satisfaction rate was met for all questions except one: "Did your Care Manager help you get the healthcare services that you needed?" Barriers and opportunities for improvement were identified, and as a result, ATC implemented the refresher trainings on Person-Centered Case Management Model for all case managers (Q3 2021), refresher Motivational Interviewing Training for all case managers (Q2 2021), and implementation of an enhanced Aunt Bertha platform to assist case management team in identifying community resources for members (Q3 2021). |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 7. Care management and coordination activities are conducted as required. | X | | | | | Overall, CM files reflected care management and coordination activities are conducted as required.<br><br>For one file, the Complex Care Management Assessment - Adult V2 completed August 3, 2020, included notations that the member reported concerns about food availability/money for food in the past 12 months. However, the CM assessment note on page 12 of the assessment states, "No economic and social conditions (SDOH) have been identified for member at this time that may impact ability to meet health care and case management goals." The care plan does not include this as a barrier or concern and there is no documentation of referrals to support services or community resources.<br><br>*Recommendation: Ensure that CM files include evidence that social determinants are identified, and referrals are made to appropriate support services or community resources, as stated in Policy CC.CM.02, Care Coordination/Care Management Services.* |
| **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 | | | | | |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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**<br>*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 | | | | | Processes and requirements for delegation are found in Policy SC.UM.18, Oversight of Delegated Utilization Management and Policy CC.CRED.12, Oversight of Delegated Credentialing. Prior to implementing a delegation agreement with a subcontractor, ATC evaluates the entity to ensure it can perform the delegated activities. For approved delegates, both parties sign a written document that serves as the delegation contract and defines performance expectations for ATC and the delegate. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | ATC reports delegation agreements with the following entities:<br>•Envolve People Care – Nurse Advice Line<br>•Envolve People Care – Disease Management<br>•Envolve Pharmacy<br>•Envolve Vision<br>•NIA<br>•AU Medical Center/AU Medical Association<br>•Medical University of South Carolina (MUSC)<br>•Prisma Health (formerly Greenville Health System)<br>•St. Francis Physician Services, Inc. (Bon Secours)<br>•CVS Caremark Minute Clinic<br>•Management and Network Services Skilled Nursing Facility<br>•Preferred Care of Aiken<br>•Health Network Solutions<br>•Prisma Palmetto Health/University of South Carolina Medical Group<br>•AnMed Health<br>•Roper St. Francis Physicians Network<br>•Regional HealthPlus - Spartanburg<br>•Lexington County Health Services District<br>•Bons Secours Ambulatory Services – St. Francis LLC dba AFC Urgent Care |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| 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 | | | | | ATC is accountable for all delegated services. Delegate performance is monitored through routine delegate reporting and JOC meetings. In addition, annual formal evaluations are conducted to assess delegate performance and compliance to required standards.<br>The documentation submitted for delegation oversight revealed the following:<br>•For several delegates, ATC did not submit annual oversight monitoring for 2021. Although the annual evaluations were initiated as early as May 2021, the evaluations are not expected to be completed until Q1, 2022. The plan reports it is on target to have these evaluations completed by the end of Q1 2022. These delegates included Envolve People Care – Nurse Advice Line, Envolve People Care – Disease Management, Envolve Pharmacy, Envolve Vision, and National Imaging Associates, Inc (NIA). For these delegates, the plan submitted evidence of quarterly JOC meetings, daily output files, monthly activity reports, utilization detail and summary reports, and/or monthly and quarterly performance review reports. Utilization management file review tools include all required elements.<br>•Oversight documentation for credentialing delegates reflected ATC includes policies and procedures, committee minutes and activity, ongoing monitoring results, and file review. Credentialing/recredentialing |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | file review tools include all required credentialing elements. Documentation of the most recent annual evaluation confirmed ATC offers recommendations, implements corrective actions as needed for any identified deficiencies, and conducts follow-up to ensure the delegates address the findings.<br><br>*Recommendation: Complete annual oversight monitoring in a timely manner.* |

## VII. STATE-MANDATED SERVICES

| STANDARD | SCORE | | | | | COMMENTS |
|---|---|---|---|---|---|---|
| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| **V I I. STATE-MANDATED SERVICES**<br>*42 CFR Part 441, Subpart B* | | | | | | |
| 1. The MCO tracks provider compliance with: | | | | | | |
| 1.1 administering required immunizations; | X | | | | | ATC measures provider compliance with administering required immunizations through medical record compliance audits and HEDIS reporting measures. Preventive and clinical |

| STANDARD | SCORE | | | | | COMMENTS |
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| | Met | Partially Met | Not Met | Not Applicable | Not Evaluated | |
| | | | | | | guidelines are posted on ATC's website, listed in the Provider Manual, and are available in hard copy upon request. |
| 1.2 performing EPSDTs/Well Care. | X | | | | | ATC measures provider compliance with performing required EPSDT services through medical record compliance audits and HEDIS reporting measures. Preventive and clinical guidelines are posted on ATC's website, listed in the Provider Manual, and are available in hard copy upon request. According to the EPSDT Program Description, providers are required to perform complete EPSDT medical check-ups at required intervals. All components of exams must be documented in the member's medical record.<br><br>Ongoing processes for EPSDT Program compliance monitoring are in place and ATC initiates interventions for improvement as needed. QI Outreach Teams conduct education and outreach, inform, track, and follow-up with members and providers to improve overall EPSDT screening rates and related HEDIS performance measures.<br><br>PCPs receive monthly reports that identify EPSDT eligible members on their roster that are new to ATC and have not had an EPSDT visit. ATC educates providers about EPSDT requirements and assists with outreach and notification to members of scheduled appointments. |

| STANDARD | SCORE | | | | | COMMENTS |
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| | 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 | | | During the previous EQR, Geo Access mapping reports did not include all required SCDHHS-designated Status 1 provider types. In the current EQR, it was again noted that the Geo Access mapping reports did not include all required Status 1 provider types.<br><br>*Quality Improvement Plan: Ensure corrections for all deficiencies identified in the EQR are addressed and fully implemented.* |