Constellation Quality Health

Absolute Total Care

2023 EXTERNAL QUALITY REIVEW

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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 2023 External Quality Review (EQR) that Constellation Quality Health, formerly The Carolinas Center for Medical Excellence (CCME), conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Absolute Total Care (ATC) since the 2022 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 2022 annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered.

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

Summary and Overall Findings

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

- Disenrollment Requirements and Limitations *(§ 438.56)*
- Enrollee Rights Requirements *(§ 438.100)*
- Emergency and Post-Stabilization Services *(§ 438.114)*
- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*

- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*
- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Subcontractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines *(§ 438.236, § 457.1233)*
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess ATC's compliance with the 14 Subpart D and QAPI standards as related to quality, timeliness, and access to care, Constellation Quality Health'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

ATC develops and implements policies to provide guidance about day-to-day health plan operations. The health plan adopts corporate policies when possible and captures state-specific requirements in addenda and/or footnotes. Policy CC.COMP.22, Policy Management, describes processes for policy development and ongoing review and approval; however, it does not include information that policies are sometimes presented to various committees for final review and approval. Staff are routinely educated about new and/or revised policies.

All key positions are filled, and overall health plan staffing is sufficient to ensure all required activities and services are provided.

The Compliance and Ethics Program Description 2023-2024 (Compliance Plan), Policy CC.COMP.16, Fraud, Waste and Abuse Plan, and related policies and procedures describe processes to maintain compliance with contractual, state, and federal requirements and to monitor, detect, prevent, and investigate fraud, waste, and abuse (FWA). The Centene Corporation Business Ethics and Code of Conduct (Code of Conduct) is comprehensive and addresses expectations for ethical business conduct and practices. Compliance training is mandatory for all employees at the time of hire, annually, and as needed.

The Compliance Committee is a cross-functional team of individuals from ATC's Board of Directors and senior leadership and meets quarterly. An error was noted in documentation

related to the Compliance Committee's chairperson in the Compliance Plan. Minutes of the Compliance Committee showed detailed documentation of discussions and actions taken by the committee.

ATC thoroughly investigates alleged or suspected noncompliance and illegal or improper activities to determine if violations of law or the Compliance Program have occurred. Immediate action is taken to address confirmed violations and corrective actions are developed to prevent recurrence.

Although Policy CC.COMP.36, Centene Exclusion Screening Requirements, addresses processes for conducting initial and ongoing Federal and State exclusion screenings for beneficial owners, the Board of Directors, employees, contingent workers, and vendors, it fails to address the requirement for querying the Social Security Death Master File for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO.

ATC provided Information Systems Capability Assessment documentation that demonstrates systems, staff, policies, and procedures are in place to fulfill contractual requirements. The documentation shows the MCO not only has a security-minded focus on its systems and data but also the overall physical security of its data centers. ATC's assets are backed by an extensive disaster recovery and resilience plan, which is reviewed quarterly and regularly tested. The most recent test resulted in a recovery scenario that exceeded expectations and was used as an opportunity to fine tune recovery procedure documentation.

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

Credentialing and recredentialing processes and requirements are included in the Centene Corporation Credentialing Program Description and in related policies. It was noted that the timeframe for processing credentialing applications for organizational providers was not documented in the applicable policy. The Credentialing Committee uses a peer-review process to make recommendations for credentialing and recredentialing determinations. Voting members of the committee includes network practitioners with a variety of specialties. No issues were identified in the review of a sample of initial credentialing and recredentialing files.

ATC routinely monitors network providers for sanctions and exclusions. Additionally, the Quality Improvement and Credentialing programs monitor the quality and safety of

practitioner services, and the Credentialing Committee makes decisions about provider suspensions, restrictions, or terminations after investigations are conducted.

Appropriate processes are in place for initial provider orientation and ongoing education. Ongoing provider education is conducted through routine meetings with network providers and regional training sessions. Provider updates are disseminated through Provider Manual revisions, newsletters, and ATC's website.

Providers are educated about preventive health and clinical practice guidelines and the guidelines are disseminated to providers in various ways. ATC assesses provider compliance with the guidelines through HEDIS measure monitoring and/or medical record audits. Providers are also educated about medical record documentation standards, and compliance is monitored through annual medical record audits. For 2023, the overall medical record audit score was 93.2% and no practitioners required follow-up.

Constellation Quality Health conducted a validation review of ATC's provider network. Overall, ATC met the requirements of the Network Adequacy Validation. ATC uses Portico as its provider data management system, and verification is conducted using a roster validation process. The member facing directory is updated daily. Quest Analytics time/distance reports are run weekly to evaluate access to network providers against standards defined by SCDHHS. The evaluation includes an analysis of reasons for identified deficiencies, barriers, opportunities for improvement, and prioritization of those opportunities. Interventions are developed and implemented as needed.

Although the 2023 Medicaid Network Analysis and the 2022 Quality Improvement Program Evaluation reflected use of appropriate parameters to measure access to primary care and specialty providers, documentation of the geographic access standards for primary care providers and specialists was not located in any policy.

Appointment access standards are appropriately documented across all reviewed documents. ATC annually assesses provider compliance with the appointment access standards by conducting call studies and monitoring CAHPS survey results, grievances, and appeals. For the most recent call study, goals were exceeded for routine and urgent care primary care appointments, but not met for after-hours access. ATC implemented interventions to address the identified barriers.

ATC works to ensure members can receive cultural and linguistic services. The Provider Manual includes an overview of Cultural Competency and refers readers to the website for more information. Downloadable resource materials and an online, accredited program that provides continuing education credits are accessible on the website.

ATC's searchable, printable, web-based Provider Directory includes all required provider elements but does not include an explanation that "an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs," as required by the *SCDHHS Contract, Section 3.12.5.10*.

As part of the annual EQR process for ATC, Constellation Quality Health conducted a provider access study focusing on primary care providers. Calls were successfully answered 67% of the time, which is an improvement over the previous year's rate.

Member Services

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

ATC informs members of their rights through the Member Handbook at enrollment, annually, and when changes occur, as well as in newsletters and on the website. The list of member rights is consistently documented across the Member Handbook, the Provider Manual, and ATC's website. ATC's Member Rights and Responsibilities policy (SC.MBRS.25) does not include all member rights required by the *SCDHHS Contract, Section 3.15.4.6*.

Newly enrolled members are provided with a Member Handbook and informed by letter that they may access the provider listing on ATC's website or request a Provider Directory by contacting Member Services. The Member Handbook is a comprehensive resource for members to understand their benefits and health plan services but does not adequately document coverage for newborn hearing screenings or clearly document the date of last revision.

The Member Handbook addresses member notification of changes in the benefits package and notification of provider termination. ATC has a formal policy that describes processes for notifying members of provider terminations; however, there is no policy that defines processes for notifying members of changes in the benefit package.

ATC uses appropriate processes to ensure member materials are understandable and available in alternate formats and languages as needed to meet member needs. Member materials are written at no higher than a 6th grade reading level. The Member Handbook provides information about the availability of and how to request translated materials and interpreter/language services at no cost.

The Member Services Call Center is available via a toll-free telephone number, toll-free fax, and TTY from 8:00 a.m. to 6:00 p.m., Monday through Friday. ATC monitors performance standards for the call center; however, Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, does not address the contractually required performance standard for the percentage of calls receiving a busy signal. ATC staff explained that the

call system is set up to roll calls over to another call center during high call volumes and callers do not receive busy signals. For 2022, the Call Center met or exceeded all goals, as noted in the 2022 QI Program Evaluation.

ATC uses online, print, digital, and person-to-person communication strategies to engage with members and provide information about programs and services. Similar methods are used to encourage participation in recommended preventive services.

ATC contracts with Press Ganey, a certified vendor, to conduct adult and child satisfaction surveys. For MY2022, the adult response rate improved from the previous year's response rate. Findings showed improvement in the ratings of customer service, coordination of care, rating of specialist., getting care quickly, and rating of personal doctor. The largest decline was in the rating of health care. The Child response rate also increased over the previous year's rate. Improvement occurred for the rating of health plan. The largest decline was in getting care quickly. The Child with CCC response rate improved over the previous year's rate, and the rating of health plan, coordination of care, and the rating of specialist improved. The largest decline for the CCC population was related to customer service.

ATC provides information for filing grievances in policy, materials, and their website. Steps for filing a verbal, written, or electronic grievance are described along with the appropriate associated timelines and expected acknowledgement and resolution documentation. Grievances are logged, categorized, and maintained per Contract guidelines.

Of the grievance file sample reviewed for the 2023 EQR, all grievances were resolved timely. Two grievance files contained an acknowledgement letter that exceeded the five-day notification timeframe described in ATC's Member Grievance policy. One grievance was closed with sixty days remaining when investigation notes indicate that additional information was needed from the member to resolve the grievance issues.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

ATC has developed a Quality Improvement (QI) program that includes all aspects of health care quality. ATC's 2023 Quality Program Description details the program's structure, objectives, scope, and methodology. Members and providers are informed of the QI Program via the website, the Member Handbook, and in the Provider Manual. Results of select HEDIS measures and CAHPS results are included on the website and members and providers are encouraged to contact the health plan for additional information.

ATC's Board of Directors has authority and oversight of the QI Program and is accountable for oversight of the quality of care and services provided to members. This board has

delegated the operating authority to the Quality Improvement Committee (QIC). ATC's Chief Medical Officer is the senior quality executive responsible for monitoring and directing all quality activities. The Behavioral Health Medical Director is responsible for the behavioral health aspects of the QI Program. The QIC meets at least quarterly with additional meetings scheduled as needed. The committee meeting minutes demonstrated this committee met the meeting frequency and quorum requirements.

Annually, ATC develops a QI work plan to identify the planned activities related to program priorities. The work plan reflects the ongoing progress of the quality activities that are reported to the QIC on a quarterly basis. The 2022 and 2023 Work Plans were submitted for review.

The QI Program Description describes the Preventive Health Reminder Program. This program's aim is to improve the adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. There was no program description or policy that outlines the specifics for tracking and monitoring adherence to the Preventive Health Program.

ATC's EPSDT Program serves members from birth through the month of their 21st birthday. This program is designed to ensure members are aware of the EPSDT requirements that include access to required screenings and necessary treatment services. The QI Outreach Team conducts education and outreach to members and providers to improve overall screening rates.

An assessment of the effectiveness of the QI program for the year is prepared annually. ATC's 2022 Quality Improvement Program Evaluation provided a systematic analysis of ATC's performance of the QI activities and evaluated the overall effectiveness of the program.

Performance Measure Validation: ATC produces HEDIS rates using software from an NCQA-certified measure vendor. 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 measures for the current measure year (2022), the previous measure year (2021), and the change from 2021 to 2022 are reported in the QI section of this report. *Table 1: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures found to have substantial rate increases or decreases from 2021 to 2022. Rate changes shown in green indicate a substantial improvement (>10%). There were no rates that showed a substantial decline (>10%).

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2021	Measure Year 2022	Change from 2021 to 2022
Substantial Increase in Rate (>10% improvement)			
Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (fua)			
30-Day Follow-Up: Total	12.33%	26.07%	13.74%
Controlling High Blood Pressure	42.82%	56.69%	13.87%

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

For the 2023 review, two PIPs were submitted and validated. As noted in tables that follow, a summary of each PIP's status and interventions is included.

Table 2: Hospital Readmissions PIP

Hospital Readmissions	
The Hospital Readmissions PIP aims to reduce annual rate of readmissions within 30 days for 18–64-year old patients. This PIP has three measurement periods. The baseline rate for number of hospital readmissions that occur within 30 days of an inpatient discharge was 18.0%, which reduced to 16.2% in 2021, then 15.5% in 2022. The rate has met the benchmark.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% 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 readmissions. • 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. • 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. • 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. • 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.	

Table 3: Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The PIP showed improvement in the rate from MY2020 at 77.28% to MY2021 at 78.18%. The benchmark is 81.97%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • Eliza application for scheduling appointments and member outreach. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. • Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.	

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)

For this EQR, Constellation Quality Health's review of the UM program included a review of various program descriptions, policies, approval files, denial files, appeal files, and care management files. ATC's various program descriptions and policies outline the overall structure, lines of responsibility, and accountability for the health plan's UM Program for physical health, behavioral health, and pharmacy services. Centene Advanced Behavioral Health is integrated within the UM Program and provides management of behavioral health services for members. Centene Pharmacy Services is the pharmacy benefit manager for ATC and CVS Caremark provides claims processing for Centene Pharmacy Services.

The Medical Director provides overall oversight of the UM Program. Also, the Behavioral Health Director and Pharmacy Director provides clinical oversight of their respective programs. ATC's UM reviewers are licensed clinicians within their respective disciplines and utilize various evidence based criteria and guidelines to make initial clinical determinations. Level II medical necessity reviews are conducted by a Medical Director or licensed practitioner with an appropriate clinical expertise.

Standard authorizations are processed within fourteen calendar days and urgent preservice requests are processed within three calendar days. However, inconsistencies were identified within the UM Program Description and Policy CC.UM.05, Timeliness of UM Decisions, regarding the timeframe for providers to notify ATC of a service authorization request.

Annually, ATC conducts Inter-Rater Reliability (IRR) testing for physicians and UM reviewers. Review of the scores yielded that most staff met the target goal. However, the UM reviewers that did not receive a passing score received additional coaching and one UM reviewer received a corrective action plan, which resulted in a passing score.

Policy SC.UM.54, Preferred Provider Designation, described the health plan's Preferred Provider Designation process. However, during onsite discussion, ATC was unable to sufficiently describe their Preferred Provider Designation process and does not have an identified process of providing provider awareness of the program.

The Provider Manual, Member Handbook, and various policies outline the role of the Pharmacy and Therapeutic committee and the Preferred Drug List (PDL) process. There was a discrepancy identified regarding the timeline that new members are allowed to receive PDL medications in Policy CC.PHAR.09, Attachment SC Addendum and the Provider Manual; however, the discrepancy was adequately explained during onsite discussion.

Constellation Quality Health's review of the sample approval files demonstrated that the approval decisions were performed appropriately and according to contractual standards.

Review of the sample denial files reflected that files were completed in a timely manner. However, there were four denial files wherein the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request.

ATC's various program descriptions and policies outline processes and guidelines for providing care management, disease management, and transition of care management to members. Members are identified and referred for case management services through

several referral sources and members that are identified as poor health and specific population health categories are flagged as high priority referrals.

Once a member is referred as a potential candidate for care management services, an assessment is completed, and the members are provided integrated care management activities based upon their stratification level and identified needs. Targeted Case Management Services are also provided for special population members. Also, during onsite discussion, ATC described several program initiatives that were recently developed to address members' needs and gaps in care.

The transition of care process is outlined in various policies. Also, two policies describe that members are made aware of the transition of care process through member materials, Member Handbook, and website. However, there is no information provided in the Member Handbook that addresses the transition of care process. Additionally, there was no verbiage identified within policies or program descriptions that addressed that the health plan assists new members with requesting copies of their medical records from treatment providers.

Review of the sample care management files yielded that care management activities are conducted according to contractual regulations.

Processes for handling appeals are addressed in Policy SC.MM.13, Member Appeals, the Member Handbook, and the Provider Manual. The definition of an appeal is consistently described as a request to review an "…adverse benefit determination." Appeals may be filed by a member, their authorized representative, or a provider on behalf of the member. Appeals are categorized and trends are reported quarterly to the Utilization Management Committee as reflected in quarterly minutes.

Of the sample of appeal files reviewed, ATC's processes were compliant with contractual and policy standards. All appeal files were acknowledged, reviewed by the appropriately credentialed reviewers, and resolved timely. Investigation notes and communication to members and providers were thoroughly detailed.

Delegation

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

ATC delegates to subcontractors and/or vendors to perform some health plan activities, including case management, utilization management, network management, and credentialing. All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Prior to delegation, ATC conducts an evaluation of the potential delegate by

conducting a pre-delegation audit. Each delegate is subject to a formal review at least once a year following the pre-delegation audit. For this EQR, ATC provided a copy of the pre-delegation and annual audits conducted for all delegates. Review of the oversight documentation revealed that audits of credentialing delegates is conducted annually and includes review of policies and procedures, committee minutes, ongoing reporting and monitoring, and a review of credentialing and recredentialing files. The oversight documentation confirmed that the file review included all required credentialing and recredentialing elements. However, there was some inconsistency regarding whether recommendations for improvement were given or corrective action was implemented. This was discussed with ATC, and it was explained that due to NCQA requirements, certain elements, if not met, require corrective action.

Mental Health Parity Assessment

The Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008 requires health plans to cover behavioral health/substance use disorder and medical/surgical benefits equally. Constellation Quality Health is required to conduct a Mental Health Parity assessment to determine if ATC met the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment is conducted as a two-step process. Step one involves assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards, and reimbursement rates, policies, and other limits on the scope or duration of benefits.

ATC provided their Medical Program Descriptions, various utilization and network access reports, Member and Provider Handbooks. The corresponding documents for Mental Health/Substance Use Disorder and the QTL templates were not provided; therefore, Constellation Quality Health was unable to complete the Parity Assessment.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, two standards were scored as “Partially Met.” The following is a high-level summary of those deficiencies:

- The Credentialing Committee Charter, found on page 13 of the 2022 Quality Program Description, states the committee composition includes network practitioners; however, the 2022 committee roster indicates one external practitioner member of the committee is not a network provider.

- The annual delegation oversight documentation was not submitted for Envolve People Care Behavioral Health. Also, the Credentialing Committee minutes did not reflect the review and discussions of the credentialing delegation oversight.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found that some of the previously identified issues were not corrected. These are addressed in the applicable sections of this report.

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 14 Subpart D and QAPI standards.

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

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. C	1	1	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	2	1	50%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Availability of Services (§ 438.206, § 457.1230) • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	12	9	75%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	13	12	92%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	41	40	98%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	20	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	1	1	50%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	10	10	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	16	16	100%

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

As noted in the table above:

- For Enrollee Rights Requirements, Policy SC.MBRS.25, Member Rights and Responsibilities, does not include the member right required by the *SCDHHS Contract, Section 3.15.4.6* 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."
- For Availability of Services and Assurances of Adequate Capacity and Services, documentation of the geographic access standards for primary care providers and specialists was not located in any policy and the web-based Provider Directory did not include a contractually required statement that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs.
- For Coverage and Authorization of Services, four sample adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral appeal request.
- For Provider Selection, Policy CC.CRED.09, Organizational Assessment and Reassessment, does not define the timeframe within which ATC will process credentialing applications for organizational providers.

- For Delegation, there is no indication that the health plan's Credentialing Committee reviews and discusses credentialing delegation oversight activities.

Table 5: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2022 review. For 2023, 207 out of 219 standards received a score of "Met." There were 10 standards scored as "Partially Met," and two standards received a "Not Met" score.

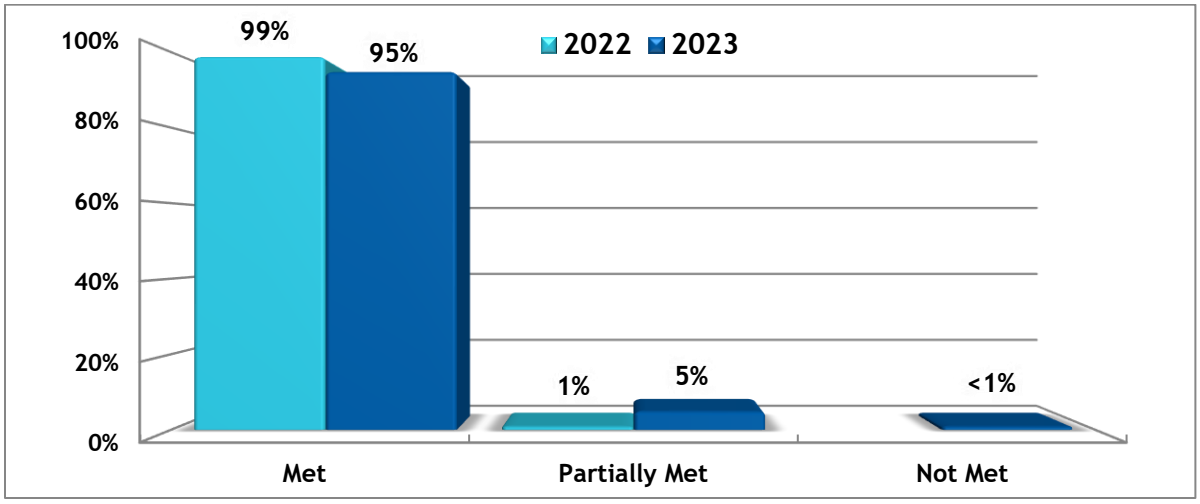
Table 5: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	40	0	0	0	0	40	100%
2023	39	1	0	0	0	40	98%
Provider Services							
2022	75	1	0	0	0	76	99%
2023	76	4	0	0	0	80	95%
Member Services							
2022	33	0	0	0	0	33	100%
2023	32	1	0	0	0	33	97%
Quality Improvement							
2022	14	0	0	0	0	14	100%
2023	16	0	0	0	0	16	100%
Utilization							
2022	46	0	0	0	0	46	100%
2023	43	3	0	0	0	46	93%
Delegation							
2022	1	1	0	0	0	2	50%
2023	1	1	0	0	0	2	50%
Mental Health Parity							
2023	0	0	2	0	0	2	0%
Totals							
2022	213	2	0	0	0	215	99%
2023	207	10	2	0	0	219	95%

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

The 2023 EQR shows that ATC achieved "Met" scores for 95% of the standards reviewed, as the following chart indicates. This chart provides a comparison of the current review results to the 2022 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 6: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
ATC develops and implements policies to guide staff in the day-to-day operations of the health plan. When possible, ATC adopts corporate policies and uses addenda and footnotes to define additional state-specific requirements.	✓		
All Key Positions are filled, and staffing is sufficient to ensure required services are provided.	✓		
Multiple data centers are in place to ensure system and data resilience. ATC has an extensive Disaster Recovery plan that is regularly tested.	✓		
ATC's Compliance and Ethics Program Description 2023-2024 and the Fraud, Waste and Abuse Plan address the Compliance Program and activities to prevent, detect, and respond to fraud, waste, and abuse. Related policies and procedures provide additional, detailed information about compliance and FWA detection and prevention activities.	✓		
The Centene Corporation Business Ethics and Code of Conduct is comprehensive and addresses expectations for ethical business conduct and practices.	✓		

Strengths	Quality	Timeliness	Access to Care
ATC investigates alleged or suspected noncompliance and illegal/improper activities and takes immediate action to address confirmed violations.	✓		
Policies, the Code of Conduct, the Compliance Plan, and other materials addresses confidentiality of member information and other protected information.	✓		
Provider Services			
ATC's Credentialing Committee makes recommendations for credentialing and recredentialing determinations using a peer-review process. Membership includes network practitioners with specialties of the Anesthesiology, Pediatrics, Psychiatry, Family Medicine, Internal Medicine, and Emergency Medicine.	✓		
All initial credentialing and recredentialing files for practitioners and organizational providers were compliant with credentialing processes and requirements.	✓		
ATC contracts with all required Status 1 provider types.			✓
The 2023 Medicaid Network Analysis and the 2022 Quality Improvement Program Evaluation reflected use of appropriate parameters to measure access to specialty care providers.			✓
ATC routinely conducts appointment and after-hours access surveys to ensure provider compliance with related access standards.			✓
ATC implements short-and long-term interventions to address network deficiencies.			✓
The successful call rate for the provider access study conducted by Constellation Quality Health improved from the previous year.			✓
The Provider Manual includes an overview of Cultural Competency and refers readers to the website for more information. ATC's website allows providers to download cultural competency resource materials and provides a link to an online, accredited program that provides continuing education credits.			✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
ATC communicates preventive health and clinical practice guidelines to providers and assesses compliance with the guidelines through HEDIS measure monitoring and/or medical record audits.	✓		
Provider compliance with medical record documentation standards is routinely assessed through medical record audits.	✓		
Member Services			
Members are informed of their rights through the Member Handbook, in newsletters, and on ATC's website.	✓		
The Member Handbook is a comprehensive resource for members to understand their benefits as well as health plan services and processes.			✓
ATC ensures member materials are understandable and available in alternate formats as needed to meet member needs.			✓
For 2022, the Call Center met or exceeded all performance goals.	✓		
ATC uses various communication strategies to provide information about programs and services and to encourage members to get recommended preventive services. These include welcome packets, telephonic outreach, email, automated text messages and calls, newsletters, etc.			✓
Member satisfaction results for Child and Adult are examined internally.	✓		
For the 2023 EQR sample of grievance files reviewed, all were resolved timely.		✓	

Strengths	Quality	Timeliness	Access to Care
Quality Improvement			
The 2023 Quality Program Description and the 2022 Quality Improvement Program Evaluation was detailed and contained a description, and a review and results of all aspects of the program.	✓		
The PIPs met the validation requirements and received scores within the High Confidence range.	✓		
The following HEDIS MY 2022 measure rates had a greater than 10 percentage point improvement: • 30-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) improved 13.74% • Controlling High Blood Pressure improved 13.87%.	✓		
Utilization Management			
ATC maintained a monthly goal of 97% or higher, exceeding the goal of 95%, in processing service authorization requests in a timely manner.		✓	
ATC recently developed a program, Choosing Tomorrow, to address suicide prevention for members.	✓		
A Housing Coordinator position was recently developed to aid in addressing homelessness and unstable housing for members.	✓		
ATC developed program initiatives to address the disparity of medication adherence for minority members that entails outreach and education.			✓
For the 2023 EQR sample of appeal files reviewed, all were acknowledged, extended if needed, and resolved timely.		✓	
Delegation			
ATC provided documentation of oversight conducted for the non-credentialing and the credentialing delegates. For this EQR, ATC provided the annual evaluation for all entities and no issues were identified.	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Administration				
Policy CC.COMP.22, Policy Management, indicates that after policies are reviewed/revised by the Policy Manager, they are reviewed and approved by up to three Policy Approvers, who are directors or vice president level staff. The policy states that once final approval is received from the Policy Approver(s), the policy is published for staff use. However, onsite discussion confirmed some policies go to committees for final review and	Recommendation: Revise Policy CC.COMP.22 to include information related to policy review and approval by various committees, such as the Utilization Management Committee, Quality Improvement Committee, etc.	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
approval. This process is not documented in Policy CC.COMP.22.				
The review revealed that the attachments to the Compliance Plan included two identical documents. Upon examination, it was confirmed that both attachments are the Compliance and Ethics Program Description 2023-2024. This was discussed during the onsite and ATC confirmed that identical documents were inadvertently listed as two different attachments to the Compliance Plan.	Recommendation: Review the attachments to the Compliance Plan and ensure the corrected documents are included.	✓		
Page 10 of the 2022 Quality Improvement Program Evaluation, under the heading "Compliance Program," lists a barrier, stating, "The performance of some health plan operations at corporate locations necessitates the need for regular and open communications." Recommendations following the barrier included: • Continue training and education related to compliance policies • Have well publicized disciplinary standards • Prompt response to compliance issues However, no documentation was included to explain the barrier and related recommendations.	Recommendation: When issues are identified that necessitate the identification of barriers and/or interventions, ensure that the issue is identified in the applicable document.	✓		
Policy CC.COMP.36, Centene Exclusion Screening Requirements, does not address querying the Social Security Death Master File (SSDMF) for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO, as required by the *SCDHHS Contract, Section 11.2.10*. During onsite discussion, ATC staff were unable to verbalize the process for conducting SSDMF queries for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO.	Quality Improvement Plan: Revise Policy CC.COMP.36, Centene Exclusion Screening Requirements, or develop a South Carolina-specific policy to define the process for conducting queries of the SSDMF for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO.	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
The South Carolina Market Compliance Committee Charter indicates both the VP of Compliance (Compliance Officer) and the Plan President chair the Compliance Committee. However, the Compliance Plan states the Compliance Officer chairs the committee. Onsite discussion confirmed that the Compliance Officer and the Plan President co-chair the committee.	Recommendation: Revise the Compliance Plan to accurately document the staff members who chair the Compliance Committee.	✓		
Provider Services				
Policy CC.CRED.09, Organizational Assessment and Reassessment, does not define the timeframe within which ATC will process credentialing applications for organizational providers.	Quality Improvement Plan: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers.		✓	
Documentation of the geographic access standards for primary care providers and specialists was not located in any policy.	Quality Improvement Plan: Revise the attachment to Policy CC.PRVR.47, to include the geographic access standards for primary care providers and specialists.			✓
The *SCDHHS Contract, Section 3.12.5.10*, requires that the Provider Directory include "An explanation to all potential Members that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs." This explanation was not noted in the online Find a Provider tool.	Quality Improvement Plan: Add a statement to the online Find a Provider Tool that when multiple members of a family are enrolled with ATC, they may all choose the same PCP, or they may choose different PCPs for each family member.	✓		
Member Services				
Policy SC.MBRS.25, Member Rights and Responsibilities, does not include the member right 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." Refer to the *SCDHHS Contract, Section 3.15.4.6*.	Quality Improvement Plan: Revise Policy SC.MBRS.25 to include that members have a right to exercise their rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat members.			✓
Per the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18*, newborn hearing screenings are "included in the Core Benefits when they are rendered to newborns in an inpatient hospital	Recommendation: Revise the Member Handbook to indicate that newborn hearing screenings are covered when conducted in the inpatient setting.			✓

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
setting." However, the Member Handbook, page 33, only addresses hearing screenings as part of routine EPSDT services.				
The *SCDHHS Contract, Section 3.12.2.16*, requires the Member Handbook to include the date of the last revision. Onsite discussion confirmed that the notation of "ATC-09012022-M-1-WM-U" on page 1 of the Member Handbook indicates the handbook was last revised and submitted to SCDHHS for approval on September 1, 2022.	Recommendation: Revise the Member Handbook to clearly indicate the date of last revision, as required by the *SCDHHS Contract, Section 3.12.2.16*.	✓		
ATC staff confirmed there is no policy that defines processes for notifying members of changes in the benefit package.	Recommendation: Create a policy to detail the processes and timeframes for notifying members of changes in the benefits package.	✓		
The *SCDHHS Contract, Section 3.17.17.3*, states "No more than two (2) percent of incoming calls shall receive a busy signal per day." This requirement is not addressed in Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance. This was discussed during the onsite, and ATC staff responded that the call system is set up to roll calls over to another call center during high call volumes; therefore, callers will not receive busy signals.	Recommendation: Revise Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, to include information that during high call volumes, calls are routed to additional call centers and members do not receive busy signals.	✓		
Quality Management				
There was no program description or policy that outlines the specifics for tracking and monitoring adherence to the Preventive Health Program.	Recommendation: Develop a program description or a policy that addresses the process used by ATC to track and monitor provider and member adherence to the Preventive Health Program.	✓		
Utilization Management				
Policy SC.UM.01, UM Program Description, states that practitioners must notify ATC within ten calendar days for prior authorization requests; however, Policy CC.UM.05 Timeliness of UM Decisions states the timeframe of within five business days for providers to provide notification of an authorization request.	Quality Improvement Plan: Please identify the correct timeframe for providers to submit prior authorization requests and ensure that the timeframe is consistent within your policy and program description.	✓		
Policy SC.UM.54, Preferred Provider Designation, provides an overview of the Preferred Provider process.	Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the *SCDHHS Contract, Section*	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
However, during onsite discussion, ATC was unable to sufficiently describe their Preferred Provider Designation process. ATC stated that once a provider obtains Preferred Provider status that it is communicated to the provider; however, ATC was unable to describe their process for identification and tracking preferred provider status. Also, ATC was not able to describe the health plan's process of providing awareness to the providers about the program.	*8.5.2.8* and outlined in Policy SC.UM.54, Preferred Provider Designation, with a process of providing provider awareness of the program.			
There were four sample denial files wherein the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request.	Quality Improvement Plan: Remove the requirement to submit a written appeal after an oral appeal request from adverse benefit determination notices.	✓		
Policy CC.UM.20, Continuity and Coordination of Services, and Policy CC.CM.02, Care Coordination Care Management Services, state that members are made aware of the transition of care process through member materials, Member Handbook, and website. However, there is no information provided in the Member Handbook that references the transition of care process.	Recommendation: Provide an outline of the transition of care process in the Member Handbook.	✓		
There was no verbiage provided in policy or program description that addresses that the health plan assists new members with requesting copies of their medical records from treatment providers.	Recommendation: Address within a policy that the health plan assists new members with requesting copies of their medical records from treatment providers as required *per SCDHHS Contract Section 5.6.3*.	✓		
Delegation				
Policy CC.CRED.12, Oversight of Delegated Credentialing, Section IV (Annual Evaluation), item E states, "Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval." During the previous EQR, ATC reported that results of the annual oversight activities are reported to the health plan's QIC (for	Quality Improvement Plan: Ensure Credentialing Committee Minutes clearly and completely document review and discussion of credentialing delegation oversight activities.	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). However, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of credentialing delegation oversight. A copy of the 2022 – 2023 SC Delegation Report was included in the folder with the Credentialing Committee minutes, however, it was not mentioned in any of the minutes reviewed.				
Mental Health Parity Assessment				
Insufficient documentation was provided by the health plan to conduct the assessment of Mental Health Parity.	Quality Improvement Plan: In order to determine compliance with the Mental Health Parity and Addiction Equity Act, ATC must complete the Mental Health Parity templates and reports and submit these documents to Constellation Quality Health for review.	✓		

METHODOLOGY

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

On October 16, 2023, Constellation Quality Health 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 and reviewed in Constellation Quality Health'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 December 6, 2023, and December 7, 2023. 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's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between 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 in each section.

A. Administration

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

The review of the Administration section encompasses policy development and management, staffing, information systems, compliance/program integrity, and confidentiality.

ATC develops and implements policies to provide guidance about day-to-day health plan operations. The health plan adopts corporate policies when possible and captures state-specific requirements in addenda and/or footnotes. Policy CC.COMP.22, Policy Management, describes processes for policy development and ongoing review and approval; however, it does not include information that policies are sometimes presented to various committees for final review and approval. Staff are educated about new and/or revised policies by departmental leadership and via monthly emails from the Compliance Department.

The organizational chart, the Absolute Total Care Key Personnel document, and discussion with ATC staff confirmed that all key positions are filled. Overall health plan staffing is sufficient to ensure all required activities and services are provided. ATC reported that only one staff position is currently vacant.

The Compliance and Ethics Program Description 2023-2024 (Compliance Plan), Policy CC.COMP.16, Fraud, Waste and Abuse Plan, and related policies and procedures describe processes to maintain compliance with contractual, state, and federal requirements and to monitor, detect, prevent, and investigate fraud, waste, and abuse (FWA). The Centene Corporation Business Ethics and Code of Conduct (Code of Conduct) is comprehensive and addresses expectations for ethical business conduct and practices. The Compliance Plan addresses compliance training for employees, subcontractors, and the Board of Directors. For employees, training is required at the time of hire, annually, and as needed.

The Compliance Committee is a cross-functional team of individuals from ATC's Board of Directors and senior leadership. The Compliance Committee meets at least quarterly, and the quorum is defined as the presence of at least 50% of the voting members (or their designee) of the committee. Onsite discussion confirmed the Compliance Officer and the Plan President co-chair the Compliance Committee, as documented in the committee's charter document. However, the Compliance Plan states the Compliance Officer chairs the committee. Minutes of the Compliance Committee confirmed detailed documentation of discussions and actions taken by the committee.

ATC investigates all alleged or suspected noncompliance and illegal or improper activities to determine if violations of law or the Compliance Program have occurred. Immediate

action is taken to address confirmed violations and corrective actions are developed to prevent recurrence. The FWA Plan provides additional, detailed information about actions taken to investigate and respond to actual or suspected FWA.

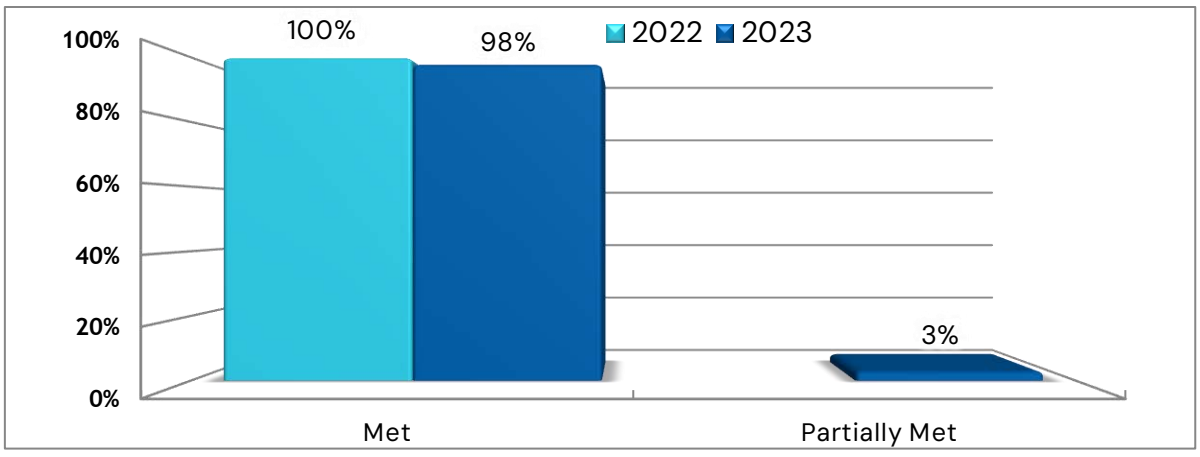
Policy CC.COMP.36, Centene Exclusion Screening Requirements, addresses processes for conducting initial and ongoing Federal and State exclusion screenings for beneficial owners, the Board of Directors, employees, contingent workers, and vendors. The policy lists the queried databases as, at minimum, the Office of Inspector General's List of Excluded Individuals/Entities, the General Services Administration's System for Award Management, and state exclusion lists for states in which Centene operates. However, the policy does not address querying the Social Security Death Master File for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. This requirement is noted in the *SCDHHS Contract, Section 11.2.10*.

Information Management Systems Assessment

ATC provided Information Systems Capability Assessment documentation that demonstrates systems, staff, policies, and procedures are in place to fulfill the contractual requirements. The documentation shows the MCO not only has a security-minded focus on its systems and data but also the overall physical security of its data centers. ATC's assets are backed by an extensive disaster recovery and resilience plan, which is reviewed quarterly and regularly tested. The most recent test resulted in a recovery scenario that exceeded expectations and was used as an opportunity to fine tune recovery procedure documentation.

As noted in *Figure 2: Administration Findings*, ATC achieved scores of "Met" for 98% of the Administration standards. One standard was scored as "Partially Met," as noted in *Table 7: Administration Comparative Data*.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number.

Table 7: Administration Comparative Data

Section	Standard	2022 Review	2023 Review
Compliance/ Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including: Exclusion status monitoring	Met	Partially Met

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

Strengths, weaknesses, recommendations, and the quality improvement plan are detailed in *Table 8: Administration Strengths* and *Table 9: Administration Weaknesses, Recommendations, and Quality Improvement Plans*.

Table 8: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
ATC develops and implements policies to guide staff in the day-to-day operations of the health plan. When possible, ATC adopts corporate policies and uses addenda and footnotes to define additional state-specific requirements.	✓		
All Key Positions are filled, and staffing is sufficient to ensure required services are provided.	✓		
Multiple data centers are in place to ensure system and data resilience. ATC has an extensive Disaster Recovery plan that is regularly tested.	✓		
ATC's Compliance and Ethics Program Description 2023-2024 and the Fraud, Waste and Abuse Plan address the Compliance Program and activities to prevent, detect, and respond to fraud, waste, and abuse. Related policies and procedures provide additional, detailed information about compliance and FWA detection and prevention activities.	✓		
The Centene Corporation Business Ethics and Code of Conduct is comprehensive and addresses expectations for ethical business conduct and practices.	✓		
ATC investigates alleged or suspected noncompliance and illegal/improper activities to determine and takes immediate action to address confirmed violations.	✓		
Policies, the Code of Conduct, the Compliance Plan, and other materials addresses confidentiality of member information and other protected information.	✓		

Table 9: Administration Weaknesses, Recommendations, and Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy CC.COMP.22, Policy Management, indicates that after policies are reviewed/revised by the Policy Manager, they are reviewed and approved by up to three Policy Approvers, who are directors or vice president level staff. The policy states that once final approval is received from the Policy Approver(s), the policy is published for staff use. However, onsite discussion confirmed some policies go to committees for final review and approval. This process is not documented in Policy CC.COMP.22.	Recommendation: Revise Policy CC.COMP.22 to include information related to policy review and approval by various committees, such as the Utilization Management Committee, Quality Improvement Committee, etc.	✓		
The review revealed that the attachments to the Compliance Plan included two identical documents. Upon examination, it was confirmed that both attachments are the Compliance and Ethics Program Description 2023-2024. This was discussed during the onsite and ATC confirmed that identical documents were inadvertently listed as two different attachments to the Compliance Plan.	Recommendation: Review the attachments to the Compliance Plan and ensure the corrected documents are included.	✓		
Page 10 of the 2022 Quality Improvement Program Evaluation, under the heading "Compliance Program," lists a barrier, stating, "The performance of some health plan operations at corporate locations necessitates the need for regular and open communications." Recommendations following the barrier included: • Continue training and education related to compliance policies • Have well publicized disciplinary standards • Prompt response to compliance issues However, no documentation was included to explain the barrier and related recommendations.	Recommendation: When issues are identified that necessitate the identification of barriers and/or interventions, ensure that the issue is identified in the applicable document.	✓		
Policy CC.COMP.36, Centene Exclusion Screening Requirements, does not address querying the Social Security Death Master File (SSDMF) for subcontractors and	Quality Improvement Plan: Revise Policy CC.COMP.36, Centene Exclusion Screening Requirements, or develop a South Carolina-specific policy to	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
persons with ownership or control interest or who are agents or managing employee of the MCO, as required by the *SCDHHS Contract, Section 11.2.10*. During onsite discussion, ATC staff were unable to verbalize the process for conducting SSDMF queries for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO.	define the process for conducting queries of the SSDMF for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. Ensure this process is implemented and conducted timely.			
The South Carolina Market Compliance Committee Charter indicates both the VP of Compliance (Compliance Officer) and the Plan President chair the Compliance Committee. However, the Compliance Plan states the Compliance Officer chairs the committee. Onsite discussion confirmed that the Compliance Officer and the Plan President co-chair the committee.	Recommendation: Revise the Compliance Plan to accurately document the staff members who chair the Compliance Committee.	✓		

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					ATC develops and implements policies to guide staff in the day-to-day operations of the health plan. When possible, ATC adopts corporate policies and uses addenda, footnotes, etc., to define additional state-specific requirements. Processes for policy development and management are found in Policy CC.COMP.22, Policy Management. ATC uses RSA Archer as its policy management platform. This system maintains an audit trail of all policies, and houses policies for staff access. Each department or functional area is responsible for maintaining its policies. As noted in Policy CC.COMP.22: • Each policy has one Policy Manager who reviews the policy at least annually and as needed. • Each policy has up to three Policy Approvers who are directors or vice president level staff and who approve or reject the policy after submission by the Policy Manager.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Once final approval is received from the Policy Approver(s), the policy is published. Onsite discussion confirmed some policies go to committees for final review and approval. However, this process is not documented in Policy CC.COMP.22. Staff are educated about new and/or revised policies via monthly Compliance emails and by departmental leadership. *Recommendation: Revise Policy CC.COMP.22 to include information related to policy review and approval by various committees, such as the Utilization Management Committee, Quality Improvement Committee, etc.*
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					John McClellan is ATC's President and CEO. He also oversees the Wellcare line of business.
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 Manager;	X					Melissa Luciano is the Contract Manager.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Larry Ruble is the Claims and Encounter Manager/Administrator.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Joshua Bush is the Manager – Population Health and Clinical Operations. He is a South Carolina-licensed Registered Nurse.
1.5.1 Pharmacy Director,	X					Jenna Meisner is the Vice President (VP) of Pharmacy Operations and serves as Pharmacy Director. She is a South Carolina-licensed Pharmacist.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Sharon Mancuso is the VP of Quality Improvement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Donald Pifer, VP of Network Development and Contracting, and serves as the Provider Services Manager.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Jennifer Helms, VP of Operations, serves as the Member Services Manager.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					ATC's Chief Medical Director is Barry Lewis, MD. Medical Directors include Bjorn Miller, MD and Jimmell Felder, MD. Frank Shelp, MD, is a SC-licensed, board-certified psychiatrist and serves as Behavioral Health Medical Director.
1.10 *Compliance Officer;	X					Donald Schmadel, VP of Compliance, serves as ATC's Compliance Officer.
1.10.1 *Program Integrity Coordinator;	X					Renee Strickland is the Program Integrity Coordinator.
1.10.2 Compliance/ Program Integrity Staff;	X					
1.10.3*Program Integrity FWA Investigative/Review Staff;	X					Three staff are dedicated to SC operations, including a Senior Investigator and two Investigators. All are in SC.
1.11 * Interagency Liaison;	X					Kate Buchta, Senior VP of Population Health, Quality & Clinical Operations, serves as the Interagency Liaison.
1.12 Legal Staff;	X					Quinn Henderson is ATC's Associate General Counsel.
1.13 *Behavioral Health Director.	X					Lee Jernigan is the Director of Case Management and Behavioral Health

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and serves as the Behavioral Health Director.
2. Operational relationships of MCO staff are clearly delineated.	X					ATC's Organizational Chart depicts reporting lines, and is color-coded to indicate key positions, temporary/contingent personnel, and vacant positions.
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					ATC's claims timeliness meets the State's contract requirements. Additionally, all received claims are processed within 72 hours and all claims pended for further investigation are reviewed within 48 hours.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					ATC can accept and generate HIPAA-compliant electronic transactions. ATC has a number of systems in place to ensure electronic data is complete and compliant. Paper claims that are processed electronically are also validated. Finally, ATC requires data to be HIPAA compliant and validated before being loaded in its EDI (Electronic Data Interchange) systems.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					ATC's Information Systems Capability Assessment documentation states its systems track enrollees who switch from one product line to another. Additionally, the systems can track an enrollee's initial enrollment date and link previous encounter data across

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						product lines. ATC's systems format data in accordance with HEDIS specifications.
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					ATC controls and logs report production. The logs document numerous aspects of report production. Additionally, performance reports are executed on a scheduled basis. Finally, ATC uses its Electronic Data Warehouse as a source to produce Medicaid performance reports.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ATC's systems operate and store data within secure data centers. The premises are guarded with security personnel, monitored surveillance cameras, and require authorized electronic badge access to gain entry to any area within the premises. Additionally, ATC uses hardware and software encryption solutions to protect the confidentiality and integrity of information to meet business, regulatory, and compliance requirements.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Policies are in place to keep unauthorized parties from accessing secure systems. Policies include but are not limited to complex passwords, secure file systems, encryption, and strict procedures surrounding the handling and use of PHI. Role-based

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						access controls grant system access on an as needed basis. All access change requests require management approval and are electronically documented.
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 data and systems are hosted in data centers that are capable of acting as failover locations should an incident occur at any one data center. Additionally, an extensive disaster recovery plan is in place to ensure the integrity, availability, and confidentiality of its systems and data.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Compliance and Ethics Program Description 2023-2024 (Compliance Plan) gives an overview of the Compliance Program and includes the program's purpose, scope, and program elements. Policy CC.COMP.16, Fraud, Waste and Abuse Plan, describes activities to prevent, detect, and respond to fraud, waste, and abuse (FWA). Related policies and procedures provide additional, detailed information about compliance and FWA detection and prevention activities. The review revealed that the attachments to the Compliance Plan included two identical documents. Upon examination, it was confirmed that both attachments are

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Compliance and Ethics Program Description 2023–2024. • The 1st is labeled as "Attachment 3 – SC.COMP.01 Attachment Compliance and Ethics Program Description." • The 2nd is labeled as "Attachment 19 – SC.COMP.01 Compliance and Ethics Program Description." This was discussed during the onsite and ATC confirmed that identical documents were inadvertently listed as two different attachments to the Compliance Plan. *Recommendation: Review the attachments to the Compliance Plan and ensure the corrected documents are included.*
2. The Compliance Plan and/or policies and procedures address requirements, including:		X				See the following standards for identified issues.
2.1 Standards of conduct;						The Centene Corporation Business Ethics and Code of Conduct (Code of Conduct) is comprehensive and addresses expectations for ethical business conduct and practices. The Code of Conduct applies to all employees, including directors and officers, and to subsidiaries, subcontractors, vendors, stakeholders, etc.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan identifies and describes the roles and responsibilities of the Compliance Officer and Program

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Integrity Coordinator. The Compliance Officer reports to ATC's President and updates the Board of Directors regularly. The Program Integrity Coordinator assists in coordinating FWA efforts with SCDHHS' Division of Program Integrity.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						The Compliance Plan provides an overview of compliance training provided to employees, subcontractors, and members of the Board of Directors. For employees, the training is required at the time of hire and annually. Ad hoc training may also be conducted. ATC tracks and maintains records of training and materials distributed for all employees. Members of the Board of Directors must acknowledge they have received and will comply with the Code of Conduct. Network providers receive training about identifying and reporting FWA as needed and upon request. In addition to the training program, written publications provide information about the Compliance Program, identifying and reporting

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						FWA, the Code of Conduct, privacy, etc. The Compliance Officer and Compliance Department staff receive additional, targeted training related to compliance, FWA, and confidentiality. Additional, detailed information about compliance training is included in Policy CC.COMP.10, Enterprise Compliance Training.
2.6 Lines of communication;						Page 10 of the 2022 Quality Improvement Program Evaluation, under the heading "Compliance Program," lists a barrier, stating, "The performance of some health plan operations at corporate locations necessitates the need for regular and open communications." Recommendations following the barrier included: • Continue training and education related to compliance policies • Have well publicized disciplinary standards • Prompt response to compliance issues However, there is nothing in the paragraphs preceding the listed barrier to explain the barrier or related recommendations. During onsite discussion, the Compliance Officer responded that this was included only

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						because some corporate functions, such as privacy, security, etc., necessitate the need for open communication with corporate staff. It was reported that there was no specific problem that prompted the inclusion of this barrier and recommendations in the 2022 Quality Improvement Program Evaluation. *Recommendation: When issues are identified that necessitate the identification of barriers and/or interventions, ensure that the issue is identified in the applicable document.*
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						The Compliance Plan addresses internal monitoring and auditing activities, which include: • Periodic audits of provider claims for compliance with established billing practices, regulations, and payor requirements by the SIU. • Audits of operations and functional departments by the Compliance Department for compliance with contractual requirements and applicable laws. Immediate steps are taken to address any identified issues and to prevent

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recurrence. Ongoing monitoring or subsequent reviews are implemented to ensure corrective actions is successful.
2.9 Response to offenses and corrective action;						As noted in the Compliance Plan, ATC investigates all alleged or suspected employees, subcontractor, or provider noncompliance and illegal/improper activities to determine if there is a violation of law or of the Compliance Program. Immediate action is taken to address confirmed violations and a corrective action plan is developed to prevent recurrence. Confirmed violations may result in referrals to law enforcement and other federal/state authorities, as well as termination from the provider network. The FWA Plan provides additional, detailed information about actions taken to investigate and respond to suspected FWA.
2.10 Data mining, analysis, and reporting;						Per the FWA Plan, the SIU uses analytical data-aggregation tools to conduct data mining to reveal potential FWA. In addition, SIU staff conduct quarterly data queries of paid claims to detect any unusual member patterns.
2.11 Exclusion status monitoring.						Policy CC.COMP.36, Centene Exclusion Screening Requirements, states Federal and State exclusion screening

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standards apply to Beneficial Owners, the Board of Directors, employees, contingent workers, and vendors at the time of affiliation or employment. Thereafter, monthly screening of federal and state databases is conducted to determine exclusion status. The policy provides detailed information about the process followed if an individual or entity is found to be possibly ineligible. The policy lists the queried databases as, at minimum: • Office of Inspector General's List of Excluded Individuals/Entities (OIG LEIE) • General Services Administration's System for Award Management (SAM) • State exclusion lists for states in which Centene operates Policy CC.COMP.36 does not address querying the Social Security Death Master File (SSDMF) for subcontractors and persons with ownership or control interest or who are agents or managing employees of the MCO. This requirement is noted in the *SCDHHS Contract, Section 11.2.10*. During onsite discussion, the process for conducting queries of the SSDMF was discussed. ATC staff verbalized the process for querying the SSDMF

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						for network providers at initial credentialing and monthly thereafter. However, health plan staff were unable to verbalize the process for conducting SSDMF queries for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. *Quality Improvement Plan: Revise Policy CC.COMP.36, Centene Exclusion Screening Requirements, or develop a South Carolina-specific policy to define the process for conducting queries of the SSDMF for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. Ensure this process is implemented and conducted timely.*
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Plan includes information about the functions of the Compliance Committee, which is a cross-functional team of individuals from within ATC, its Board of Directors, and other senior leadership, as needed, with authority to implement corrective actions. The Compliance Committee meets quarterly and as needed. The South Carolina Market Compliance Committee Charter describes the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						functions and composition of the Compliance Committee. The charter indicates both the VP of Compliance (Compliance Officer) and the Plan President chair the committee. However, the Compliance Plan states the Compliance Officer chairs the committee. Onsite discussion confirmed that the Compliance Officer and the Plan President co-chair the committee. The charter confirms the committee meets at least quarterly and as needed, and that a quorum is defined as the presence of at least 50% of the voting members (or their designee) of the committee. Review of the submitted Compliance Committee minutes confirmed detailed documentation of discussions and actions taken by the committee. *Recommendation: Revise the Compliance Plan to accurately document the staff members who chair the Compliance Committee.*
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Processes to prevent and detect fraud, waste, and abuse are documented throughout the FWA Plan, Information Systems Capabilities Assessment documentation, and policies.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The FWA Plan comprehensively describes the investigation process conducted by the SIU in response to FWA referrals related to network providers. Addendum Q of the FWA Plan addresses processes followed when FWA referrals are related to members. "The Contractor shall adhere to the policy and process contained in the MCO Policy and Procedure Guide for referral of cases and coordination with the Department Division of Program Integrity for fraud and abuse complaints regarding Medicaid MCO Members and Providers."
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					Policy SC.CLMS.01, ATC State Suspended Provider Payment Withhold, defines processes for provider payment suspensions resulting from a SCDHHS determination of a credible allegation of fraud. Processes for provider payment recoupment are included in the FWA Plan.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy CC.PHAR.18, Pharmacy Lock-in Program, and related addenda define ATC's Pharmacy Lock-in Program processes and requirements, which are compliant with contractual requirements.
I E. Confidentiality *42 CFR § 438.224*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Multiple policies, the Code of Conduct, the Compliance Plan, and other materials address confidentiality of member information and other protected information.

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 processes and file review, provider education processes, preventive health and clinical practice guidelines, continuity of care, processes for assessing provider compliance with medical record documentation standards, and a validation of network adequacy.

Provider Credentialing and Selection

The Centene Corporation Credentialing Program Description gives an overview of the Credentialing Program, with specific processes and requirements detailed in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment and Reassessment. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. However, the timeframe for processing credentialing applications for organizational providers was not documented.

ATC's Credentialing Committee makes recommendations for credentialing and recredentialing determinations using a peer-review process. The Medical Director oversees credentialing functions and facilitates and chairs the Credentialing Committee, which reports to the Quality Improvement Committee. Voting membership of the Credentialing Committee includes network practitioners with a variety of specialties, including Anesthesiology, Pediatrics, Psychiatry, Family Medicine, Internal Medicine, and Emergency Medicine. The quorum for the Credentialing Committee is established with the presence of at least two-thirds of the voting members. The Committee meets monthly, no less than 10 times yearly, and as needed.

An issue identified during the previous EQR related to the Credentialing Committee was found to be corrected in the current EQR. See *Table 10: Previous Credentialing Quality Improvement Plan Items,* for detailed information about the deficiency, ATC's response, and the current status of the deficiency.

Table 10: Previous Credentialing Quality Improvement Plan Items

Standard	2022 EQR Findings	2023 EQR Findings
II A. Credentialing and Recredentialing		
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	The Credentialing Committee Charter, found on page 13 of the 2022 Quality Program Description, states the committee composition includes network practitioners; however, the 2022 committee roster indicates one external practitioner member of the committee is not a network provider. During onsite discussion of this finding, ATC staff reported that non-participating providers may serve as members of the Credentialing Committee. This is not in compliance with footnote number 5 on page 3 of Policy CC.CRED.03, Credentialing Committee, which states, "Absolute Total Care requires members of the Credentialing Committee to be in-network providers." *Quality Improvement Plan: To comply with requirements of Policy CC.CRED.03, Credentialing Committee, replace the non-participating practitioner member of the Credentialing Committee with a network practitioner.*	This issue was corrected. All members of ATC's Credentialing Committee are participating in ATC's provider network.
ATC Response: ATC will replace the nonparticipating practitioner from the Credentialing Committee no later than end of 2nd Quarter 2023.		

A sample of initial credentialing and recredentialing files for practitioners and organizational providers was conducted. All of the files were compliant with credentialing processes and requirements.

As noted in health plan policy, ATC routinely monitors network providers for sanctions and exclusions by conducting queries of the National Practitioner Data Bank, the Office of Inspector General's List of Excluded Individuals and Entities, the System for Award Management, State exclusion lists, etc.

ATC's Quality Improvement and Credentialing programs monitor the quality and safety of practitioner services, and the Credentialing Committee makes decisions about provider suspensions, restrictions, or terminations after investigations are conducted. Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, describes processes for taking disciplinary action against providers, reporting to the National Practitioner Data Bank, and transitioning members to alternate providers.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

ATC conducts provider orientation within 30 business days of becoming active with ATC for all newly contracted PCPs, specialists, hospitals, and ancillary providers who are not part of an existing group or facility. The 2021 Medicaid provider orientation PowerPoint includes an overview of Centene and addresses the role of Provider Network Specialists, provider responsibilities, verifying member eligibility, member ID cards, claims submission/disputes/appeals, FWA, web-based provider tools, etc. The Provider Manual is a resource for providers to obtain detailed information about health plan processes, requirements, and services.

Ongoing provider education is conducted through routine meetings with network providers at various frequencies, based on provider type, and through training sessions held in at least four regional locations yearly. Between these meetings and training sessions, provider updates are disseminated through Provider Manual revisions, newsletters, and ATC's website.

Providers are educated about preventive health guidelines (PHGs) and clinical practice guidelines (CPGs). Copies of the guidelines are given to providers, based on specialty, but are available to all providers upon request and can be accessed on ATC's website. The Provider Manual describes the CPGs and PHGs and informs providers that ATC measures compliance with the guidelines HEDIS measure monitoring and/or medical record audits.

Providers are also educated about medical record documentation standards, which are included in the Provider Manual, and on ATC's website. ATC assesses provider compliance with medical record documentation standard through annual medical record audits, as described in Policy SC.QI.13, Medical Record Review. The Absolute Total Care Medicaid Medical Record Review 2023 Annual Audit Report indicated 355 medical records were audited across a sample of 71 practitioners. All of the practitioners received passing scores of 80% or greater, with an overall score of 93.2%, and no practitioners required follow-up.

Network Adequacy Validation

42 CFR § 438.68 (a), 42 CFR § 438.14(b)(1) 42 CFR § 457.1218. 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)

Constellation Quality Health conducted a validation review of ATC's provider network following the CMS protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the MCO is meeting network standards defined by the State. To validate ATC's network, Constellation Quality Health requested and reviewed:

- Member demographics, including total enrollment and distribution by age ranges, sex, and county of residence.
- Geographic access assessments, network development plans, enrollee demographic studies, population needs assessments, provider-to-enrollee ratios, in-network and out-of-network utilization data, provider panel size limitations.
- A complete list of network providers.
- The total numbers of unique primary care and specialty providers in the network.
- A completed Provider Network File Questionnaire.
- Provider Appointment Standards and health plan policies.
- Provider Manual and Member Handbook.
- Sample of a provider contract.

A desk review of these documents was conducted to assess network adequacy. In addition, the results of the Telephone Access Study conducted by Constellation Quality Health were considered.

Overall, ATC met the requirements of the Network Adequacy Validation. The following is an overview of the results for each activity.

Provider Network File Questionnaire

Constellation Quality Health reviewed the Provider Network File Questionnaire. ATC uses Portico as the provider data management system, and verification is conducted using a roster validation process. The member facing directory is updated daily. Quest Analytics time/distance reports are run weekly.

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

Policy CC.PRVR.47, Evaluation of Practitioner Availability, Section B (Ensuring Availability of Primary Care Practitioners) and Section C (Ensuring Availability of Specialty Care Practitioners) indicates geographic access standards for PCPs and specialists are included in an attachment to the policy. However, the attachment to this policy includes only geographic access standards for acute care hospital providers. Documentation of the geographic access standards for primary care providers and specialists was not located in any policy.

As noted in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC evaluates access to network providers, including number and geographic distribution, against standards

defined by SCDHHS, at least annually. Data sources used to conduct the evaluation include Geo Access mapping, network adequacy reports, member grievances about provider access, etc. The evaluation also includes an analysis of reasons for identified deficiencies, barriers, opportunities for improvement, and prioritization of those opportunities. Interventions are developed and implemented as needed. The 2023 Medicaid Network Analysis dated October 17, 2023, and the 2022 Quality Improvement Program Evaluation reflected use of appropriate parameters to measure access to primary care and specialty providers. In addition, the GeoAccess document dated October 17, 2023, confirmed ATC contracts with required Status 1 provider types. The 2024 Network Development Plan addresses ATC's processes for implementing short-term and long-term interventions to address any identified network deficiencies.

Appointment access standards are appropriately documented in health plan policy as well as in the Member Handbook and Provider Manual. ATC annually assesses provider compliance with the appointment access standards by conducting call studies and by monitoring CAHPS survey results, grievances, and appeals related to appointment access. ATC provided the results of the PCP routine and urgent care appointments and after-hours access call study conducted in June 2022. This call study was conducted by Faneuil, a Centene vendor. From a random sample of 3,243 practitioners, 1,125 phone surveys were completed. Goals were exceeded for routine and urgent care primary care appointments, but ATC did not meet the goal for after-hours access. The documentation provided indicated that ATC evaluated the areas that were not met to identify causes and implemented interventions to address the identified barriers.

The State has defined time/distance requirements for primary care, OB/GYN, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. The organization regularly reviews and updates the policies used to maintain data and system security. ATC conducts internal audits to ensure requirements are being met, and regularly contracts with auditors to verify its system controls.

ATC works to ensure members can receive cultural and linguistic services, as addressed in Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L). The Provider Manual includes an overview of Cultural Competency and refers readers to the website for more information about ATC's Cultural Competency and Linguistically Appropriate Services (CCLAS) Program. Downloadable resource materials are available to providers on ATC's website and providers can also access "A Physician's Practical Guide to

Culturally Competent Care," an online, accredited program that provides continuing education credits.

ATC's searchable, printable, web-based Provider Directory includes all network providers. The online directory includes all required provider elements; however, it does not include an explanation that "an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs," as required by the *SCDHHS Contract, Section 3.12.5.10*. As noted in Policy CC.PRVR.19, Provider Directory, the online provider data is sourced from the provider data management (PDM) system, and updates are automated from the PDM system. Staff update provider information in the PDM system within 30 calendar days of receiving the information. ATC conducts usability testing of the web-based directory at least every three years and conducts routine call studies/surveys to validate provider information.

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, a provider access study focusing on primary care providers was conducted. From a list of current providers supplied by ATC, a population of 2,312 unique PCPs was found. A sample of 189 providers was randomly selected from the identified PCP population for the Access Study. Attempts were made to contact these providers to ask a series of questions about the access members have with the providers. For the Telephone Provider Access Study conducted by Constellation Quality Health, calls were successfully answered 67% of the time (119 out of 178) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 61%, this year's study successful answer rate increased, although it was not significant (p = .222).

Table 11: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	Fisher's Exact p-value
2022 Review	190	61	.222
2023 Review	189	67	

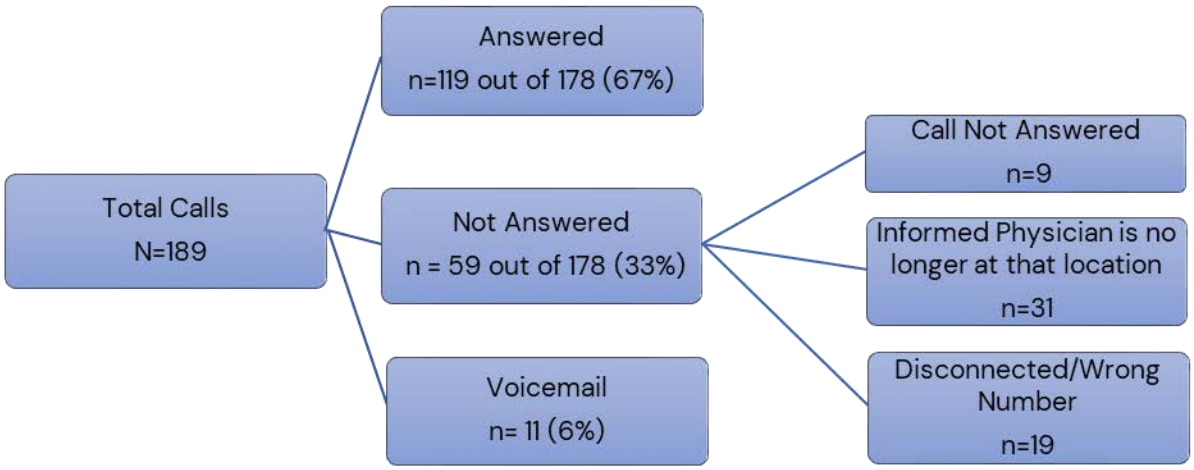
For calls not answered successfully (n= 59 calls), 31 (53%) were because the physician was no longer active at the location; 19 (32%) were due to a wrong number, hold time longer than 5 minutes, or busy signal, and nine (15%) were because the call was not answered.

Of 119 providers successfully contacted, 106 (89%) accepted ATC and 13 (11%) did not accept ATC. Of the 106 who accept ATC, 88 (83%) are accepting new patients; 18 (17%) are not accepting new patients.

A routine appointment was available within the contractual requirement (30 days) for 62 (70%) of the 88 providers that are accepting new patients and outside the required timeframe for five (6%) providers. A total of 21 of the 88 calls (24%) were unable to obtain an appointment due to the provider requesting more information, such as medical records or insurance number for the member.

Results of the call study are displayed in *Figure 2: Telephonic Provider Access Study Results*.

Figure 2: Provider Access Study Results



As noted in *Figure 3: Provider Services Findings*, 95% of the standards in the Provider Services section were scored as "Met."

Figure 3: Provider Services Findings

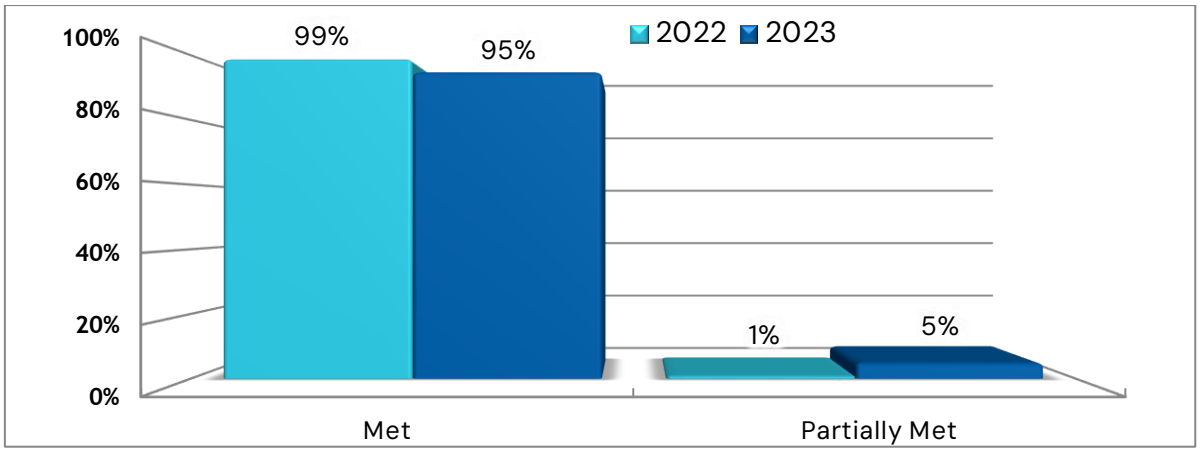


Table 12: Provider Services Comparative Data

Section	Standard	2022 Review	2023 Review
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Met	Partially Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	Partially Met	Met
Adequacy of the Provider Network	Members have a primary care physician located within a 30-mile radius of their residence.	Met	Partially Met
	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Partially Met
	The MCO regularly maintains and makes available a Provider Directory that includes all required elements	Met	Partially Met

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

Table 13: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
ATC's Credentialing Committee makes recommendations for credentialing and recredentialing determinations using a peer-review process. Membership includes network practitioners with specialties of the Anesthesiology, Pediatrics, Psychiatry, Family Medicine, Internal Medicine, and Emergency Medicine.	✓		
All initial credentialing and recredentialing files for practitioners and organizational providers were compliant with credentialing processes and requirements.	✓		
ATC contracts with all required Status 1 provider types.			✓
The 2023 Medicaid Network Analysis and the 2022 Quality Improvement Program Evaluation reflected use of appropriate parameters to measure access to specialty care providers.			✓
ATC routinely conducts appointment and after-hours access surveys to ensure provider compliance with related access standards.			✓
ATC implements short-and long-term interventions to address network deficiencies.			✓
The successful call rate for the provider access study conducted by Constellation Quality Health improved from the previous year			✓
The Provider Manual includes an overview of Cultural Competency and refers readers to the website for more information. ATC's website allows providers to download cultural competency resource materials and provides a link to an online, accredited program that provides continuing education credits.			✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
ATC communicates preventive health and clinical practice guidelines to providers and assesses compliance with the guidelines through HEDIS measure monitoring and/or medical record audits.	✓		
Provider compliance with medical record documentation standards is routinely assessed through medical record audits.	✓		

Table 14: Provider Services Weaknesses, Recommendations, Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy CC.CRED.09, Organizational Assessment and Reassessment, does not define the timeframe within which ATC will process credentialing applications for organizational providers.	Quality Improvement Plan: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers.		✓	
Documentation of the geographic access standards for primary care providers and specialists were not located in any policy.	Quality Improvement Plan: Revise the attachment to Policy CC.PRVR.47, to include the geographic access standards for primary care providers and specialists.			✓

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
The *SCDHHS Contract, Section 3.12.5.10*, requires that the Provider Directory include "An explanation to all potential Members that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs." This explanation was not noted in the online Find a Provider tool.	Quality Improvement Plan: Add a statement to the online Find a Provider Tool that when multiple members of a family are enrolled with ATC, they may all choose the same PCP, or they may choose different PCPs for each family member.	✓		

II. PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. Provider Services						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				The Centene Corporation Credentialing Program Description provides a brief overview of the Credentialing Program. Specific processes and requirements are detailed in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment and Reassessment. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. Policy CC.CRED.01 indicates ATC will process practitioner credentialing applications within 60 calendar days of receipt of a complete application, including all necessary documentation and attachments. However, Policy CC.CRED.09 does not define the timeframe within which ATC will process credentialing applications for organizational providers. *Quality Improvement Plan: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					ATC's Credentialing Committee makes recommendations for credentialing and recredentialing determinations using a peer-review process. The committee reviews credentials for practitioners and providers who do not meet established thresholds and ensures files that meet established criteria are reviewed and approved by a medical director or designated physician. The Medical Director oversees credentialing functions and facilitates and chairs the Credentialing Committee. The Credentialing Committee reports to the Quality Improvement Committee (QIC). Credentialing Committee membership includes network practitioners and ATC staff. The Medical Director and network physician attendees are the voting members. Specialties of the voting members include Anesthesiology, Pediatrics, Psychiatry, Family Medicine, Internal Medicine, and Emergency Medicine. Policy CC.CRED.03, Credentialing Committee, defines the quorum for the Credentialing Committee as the presence of at least 2/3 of the voting members. The Committee meets monthly, no less than 10 times yearly, and as needed.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					All initial credentialing files for practitioners were compliant with credentialing processes and requirements.
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					
3.1.10 Query of the State Excluded Provider's Report and	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the SC Providers Terminated for Cause List;						
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.16 Additional Requirements for Nurse Practitioners.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					All recredentialing files for practitioners were compliant with recredentialing processes and requirements.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Additional Requirements for Nurse Practitioners.	X					
4.3 Review of practitioner profiling activities.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					ATC's Quality Improvement and Credentialing programs monitor the quality and safety of practitioner services, and the Credentialing Committee makes decisions about provider suspensions, restrictions, or terminations after investigations are conducted. Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting, describes the health plan's process for taking disciplinary action against a provider (including administrative suspension, administrative termination, summary suspension and termination), reporting to the National Practitioner Data Bank, and transitioning members to alternate providers.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					All initial credentialing and recredentialing files for organizational providers were compliant with recredentialing processes and requirements.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					ATC conducts ongoing monitoring of network providers for sanctions and exclusions to ensure that no payments are made to individual providers or entities who are excluded from participation in any federal health care program. This activity is conducted by Credentialing staff and queries include NPDB reports, the OIG LEIE, state licensing boards, SAM, state exclusion lists, etc. Ongoing monitoring is addressed in Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints.
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)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
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, Section B (Ensuring Availability of Primary Care Practitioners (PCPs)) states, "At least annually, the Plan assesses the availability of PCPs within its delivery system, including number and geographic distribution, and analyzes performance against the standards as defined for each Plan (see Attachment Section)." However, the attachment to this policy addresses only geographic access standards for acute care hospital providers. Documentation of the geographic access standards for primary care providers was not located in any policy. The 2023 Medicaid Network Analysis dated October 17, 2023, and the 2022 Quality Improvement Program Evaluation reflected use of appropriate parameters to measure access to primary care providers. *Quality Improvement Plan: Revise the attachment to Policy CC.PRVR.47 to include the geographic access standards for primary care providers.*
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of		X				The GeoAccess document dated October 17, 2023, confirms ATC contracts with required Status 1 provider types.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.						Policy CC.PRVR.47, Evaluation of Practitioner Availability, Section C (Ensuring Availability of Specialty Care Practitioners (SCPs)) states, "At least annually, the Plan assesses the availability of high-volume and high-impact SCPs within its delivery system, including number and geographic distribution, and analyzes performance against the standards as defined for each Plan (see Attachment Section)." However, the attachment to this policy addresses only geographic access standards for acute care hospital providers. Documentation of the geographic access standards for specialists was not located in any policy. The 2023 Medicaid Network Analysis and the 2022 Quality Improvement Program Evaluation reflected use of appropriate parameters to measure access to specialty care providers. *Quality Improvement Plan: Revise the attachment to Policy CC.PRVR.47, to include the geographic access standards for specialty care providers.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					As noted in Policy CC.PRVR.47, Evaluation of Practitioner Availability, ATC evaluates access to network providers, including the number and geographic distribution against standards defined by SCDHHS, at least annually. Data sources used to conduct the evaluation include Geo Access mapping, network adequacy reports,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						member grievances related to practitioner access, etc. The evaluation also includes an analysis of causes of identified deficiencies, barriers, opportunities for improvement, and prioritization of those opportunities. Interventions are developed and implemented as needed.
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					Policy CC.QI.CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), provides detailed information about processes and activities to ensure members are provided with cultural and linguistic services as contractually required. The policy covers activities related to health literacy, communication, language services, reducing health disparities, cultural competency, and supporting members with disabilities. The Provider Manual includes an overview of Cultural Competency and refers readers to the website for more information about ATC's Cultural Competency and Linguistically Appropriate Services (CCLAS) Program. ATC's website allows providers to download copies of the 2023 CLAS Program Description, the Americans with Disabilities Act (ADA) – Disability Awareness Quick Reference Guide, and the Cultural Competency Quick Reference Guide. The website also links providers to "A Physician's Practical Guide to Culturally Competent Care," which is an online, accredited program that provides continuing education credits.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The 2024 Network Development Plan addresses ATC's processes for implementing short-term and long-term interventions to address network deficiencies. Examples of short-term interventions include: • Authorizing out-of-network care and single-case agreements with out-of-network providers. • Requesting providers with closed panels to make exceptions to see enrollees. • Arranging transportation for members to access care. • Maintaining relationships with in-home and telehealth providers to provide member care. Examples of long-term interventions include: • Offering long-term agreements with providers that have a single-case agreement in place. • Authorizing non-participating providers to continue care beyond a transition period. • Responding quickly to provider requests to join the network. • Employing telemedicine, incentives, and investments to expand provider capacity, etc. • Working with providers that have closed panels to potentially open panels to more members. • Encouraging providers to extend hours and expand access points.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Including access to mid-level providers who work under the supervision of a physician and can practice in remote locations even if the physician is not present.
1.6 The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. ATC uses Portico as the data management system. Verification is conducted using a roster validation process. The member facing directory is updated daily. Quest Analytics time/distance reports are run weekly.
2. Practitioner Accessibility 42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)						
2.1 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					Appointment access standards are appropriately documented in Policy SC.PRVR.15, Evaluation of the Accessibility of Services, the Member Handbook, and the Provider Manual.
2.2 The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					Policy SC.PRVR.15, Evaluation of the Accessibility of Services, describes ATC's process for conducting annual evaluations of appointment access with PCPs, behavioral health service providers, and specialty providers. The QIC analyzes results and makes recommendations to address any identified deficiencies. Provider compliance with appointment access standards is evaluated through monitoring CAHPS survey results, member grievances and appeals related to access, and site-specific surveys/audits.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Medicaid Accessibility of Services Annual Assessment 2023 was included in the QIC Binder for Q2 2023. The document states a random audit of PCP offices to monitor compliance with PCP routine and urgent care appointments and after-hours access was conducted in June 2022. The Practitioner Appointment Availability (A&A) Phone Survey was conducted by Faneuil, a Centene vendor. From a random sample of 3,243 practitioners, 1,125 phone surveys were completed. In 2022, the health plan exceeded the goals for routine and urgent care primary care appointments. However, ATC did not meet the goal for after-hours access. ATC evaluated the areas that were not met to identify causes and implemented interventions to address identified barriers. These included: • Increasing education about complying with access standards. • Increasing education about providing updated contact/demographic information in a timely manner. • Educating practitioners through monthly New Provider Orientations, provider town halls, and Joint Operations Committee (JOCs) meetings. • Suggesting providers give members an option to access other PCPs or have an answering service triage members' medical complaint(s).

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Educating providers about how to the find a provider directory to locate PCPs that are open after hours.
2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.		X				As noted in Policy CC.PRVR.19, Provider Directory – Portico, ATC maintains a searchable, printable, web-based Provider Directory that includes all network providers. The policy lists elements that must be included in the Provider Directory and details processes for maintaining provider information for the directory. Information submitted along with the desk materials for this review indicated that instead of sending members a printed provider directory, ATC sends a letter providing the member with a list of their active local providers and instructs them to call ATC or to use the find-a-provider tool on ATC's website to identify additional providers as needed. The *SCDHHS Contract, Section 3.12.5.10*, requires that the Provider Directory include "An explanation to all potential Members that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs." This explanation was not noted in the online Find a Provider tool. *Quality Improvement Plan: Add a statement to the online Find a Provider Tool that when multiple members of a family are enrolled with ATC, they may all choose the same PCP, or they*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						may choose different PCPs for each family member.
2.4 The MCO conducts appropriate activities to validate Provider Directory information.	X					Policy CC.PRVR.19, Provider Directory, states the online provider data is sourced from the provider data management (PDM) system, and updates are automated from the PDM system. The Provider Data Excellence team updates the provider information in the PDM system within 30 calendar days of receiving the information. The User Experience team conducts usability testing of the web-based directory through the Member Advisory Committee or random survey at least every three years. The testing is also conducted after any significant changes to member demographics or upgrades to functionality or design of the website. The usability is evaluated in the areas of font size, reading level, organization of content, ease of navigation, and language (if applicable). ATC conducts routine call studies/surveys to validate provider information.
2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.	X					As part of the annual EQR process for ATC, a provider access study focusing on primary care providers was conducted. ATC supplied a list of current providers. From this list, a population of 2,312 unique PCPs was found. A sample of 189 providers was randomly selected from the identified PCP population for the Access Study. Attempts were made to contact these providers to ask a series of questions about the access members have with the providers. For the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Telephone Provider Access Study conducted by Constellation Quality Health, calls were successfully answered 67% of the time (119 out of 178) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 61%, this year's study successful answer rate increased, although it was not significant (p = .222). For calls not answered successfully (n= 59 calls), 31 (53%) were because the physician was no longer active at the location; 19 (32%) were due to a wrong number, hold time longer than 5 minutes, or busy signal, and nine (15%) were because the call was not answered. Of 119 providers successfully contacted, 106 (89%) accepted ATC and 13 (11%) did not accept ATC. Of the 106 who accept ATC, 88 (83%) are accepting new patients; 18 (17%) are not accepting new patients. A routine appointment was available within the contractual requirement (30 days) for 62 (70%) of the 88 providers that are accepting new patients and outside the required timeframe for five (6%) providers. A total of 21 of the 88 calls (24%) were unable to obtain an appointment due to the provider requesting more information, such as medical records or insurance number for the member.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The State has defined time/distance requirements for primary care, OB/GYN, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. ISCA evaluation demonstrated the organization, and its information systems are capable of meeting the State's requirements. The organization regularly reviews and updates the policies used to maintain data and system security. ATC conducts internal audits to ensure requirements are being met, and regularly contracts with auditors to verify its system controls.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					As noted in Policy SC.PRVR.13, Provider Orientations, ATC conducts provider orientation for all newly contracted PCPs, specialists, hospitals, and ancillary providers if they are not part of an existing group or facility. The orientation is conducted within 30 business days of becoming active with ATC. Per onsite discussion with ATC staff, provider orientations are primarily conducted virtually, and records of provider attendance are maintained. The 2021 Medicaid provider orientation PowerPoint document includes an overview of Centene and addresses the role of Provider Network Specialists, provider responsibilities,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						verifying member eligibility, member ID cards, claims submission/disputes/appeals, FWA, web-based provider tools, etc. The Provider Manual is a resource for providers to obtain detailed information about health plan processes, requirements, and services.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					The Provider Manual covers general billing guidelines, claims submission, claim adjustments, provider disputes, code auditing and edits, billing codes and forms, third party liability, member billing, etc.
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					The Provider Manual includes information about preventive health and clinical practice guidelines and protocols. ATC encourages providers to use guidelines as a basis for member treatment plans and as an aid for members to make healthcare decisions. Lists of currently adopted preventive

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						health and clinical practice guidelines are included in the manual, and providers are directed to the website for additional information.
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					The Provider Manual describes circumstances under which a PCP may request the transfer of a member to another PCP.
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Policy SC.PRVR.14, Provider Visit Schedule/On-going Education, describes ATC's processes for providing ongoing education to its network providers. Provider/Network Relations Specialist schedule routine meetings with network providers at various frequencies, based on provider type. ATC also holds provider training sessions in at least four regional locations throughout the state at least once a year via virtual or face to face sessions. In addition, ATC notifies providers of updates through Provider Manual revisions, newsletters, the website, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II D. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health and clinical practice guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					As noted in Policy SC.QI.08, Clinical and Preventive Practice Guidelines, ATC adopts preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) that are relevant to its membership. The guidelines are sourced from recognized sources and, through the health plan's QIC, are reviewed by physicians prior to approval for adoption. The guidelines are reviewed annually and updated when there is significant new scientific evidence or changes in national standards. The PHGs include guidelines for all age ranges, and the CPGs include guidelines for acute and chronic medical conditions and behavioral health conditions which are relevant to the membership.
2. The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members.	X					Policy SC.QI.08, Clinical and Preventive Practice Guidelines, states PHGs and CPGs are disseminated to providers based on specialty and are available to all providers upon request. The guidelines are available on ATC's website in the Quality Improvement Program section. The Provider Manual includes information describing the CPGs and PHGs, the review and adoption process, and that ATC may measure compliance with the CPGs and PHGs through HEDIS measure monitoring and/or medical record audits. The Provider Manual also lists the guidelines adopted by the health plan. Providers may also be

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						educated about the guidelines through provider orientation, provider newsletters, mailings, and fax blasts.
3. The guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Processes for monitoring and evaluating continuity and coordination of care are found in Policy CC.QI.10, Continuity & Coordination Between Medical and Behavioral Health Care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Pages 33-34 of the 2023 Quality Program Description addresses activities conducted to monitor and improve continuity and coordination of care. The activities include: • Monitoring movement of members between practitioners and across care settings. • Monitoring continuity and coordination between medical and behavioral health providers. • Monitoring HEDIS measures, CAHPS or other member experience survey results, and provider satisfaction surveys. • Collecting and analyzing data related to continuity and coordination of care to identify opportunities for improvement and implementing interventions. ATC measures the effectiveness of interventions annually and analyzes re-measurement results. The 2022 QI Program Evaluation includes an overview of continuity and coordination of care activities conducted, along with an assessment of the effectiveness of interventions, barriers, opportunities for improvement, and an action plan with prioritization and implementation dates.
II F. Practitioner Medical Records						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Processes for assessing provider compliance to medical record documentation standards are detailed in Policy SC.QI.13, Medical Record Review. Specific medical record documentation requirements are included in Attachment A of the policy, in the Provider Manual, and on ATC's website. We noted that the policy was updated to include retrieving and evaluating records from electronic medical record systems. "If necessary, the QI designee may schedule the audit at the practitioner's office location or request that medical records or components thereof are mailed or faxed to ATC, or designated ATC staff representatives may pick up copies of records from the provider office and bring back to ATC."
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Standards for medical record documentation are appropriately documented across Attachment A of Policy SC.QI.13, the Provider Manual, and on ATC's website.
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 Absolute Total Care Medicaid Medical Record Review 2023 Annual Audit Report was attached to the minutes for the QIC meeting on 8/29/23. A total of 2447 practitioners were identified for inclusion in the medical record audit. A sample of 71 practitioners was selected. 355 records were audited across the 71 practitioners. All practitioners received a total passing score of 80% or greater, with an overall

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						score of 93.2%. This was a 5 percentage-point decrease from the previous year. No practitioners required follow-up action.
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					The Sample Provider Contract addresses the requirement to make medical records available for review and audits by SCDHHS and its designees as well as other agencies and includes the required record retention timeframe. In addition, the Provider Manual instructs that medical records may be audited to determine compliance with standards for medical record documentation, to validate coordination of care and services provided to members, etc.

C. Member Services

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

The review of Member Services includes member rights, member education, enrollment and disenrollment processes, member satisfaction surveys, processes for handling grievances, and a grievance file review.

ATC informs members of their rights through the Member Handbook at enrollment, annually, and when changes occur, as well as in newsletters and on the website. The list of member rights is consistently documented across the Member Handbook, the Provider Manual, and ATC's website. However, Policy SC.MBRS.25, Member Rights and Responsibilities, does not include the member right 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." Refer to the *SCDHHS Contract, Section 3.15.4.6*.

Newly enrolled members are provided with a Member Handbook and informed by letter that they may access the provider listing on ATC's website or request a Provider Directory by contacting Member Services. The Member Handbook is a comprehensive resource for members to understand their benefits and health plan services. Per the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18*, newborn hearing screenings are "included in the Core Benefits when they are rendered to newborns in an inpatient hospital setting." However, the Member Handbook, page 33, only addresses hearing screenings as part of routine EPSDT services. The *SCDHHS Contract, Section 3.12.2.16*, requires that the Member Handbook include the date of the last revision. Onsite discussion confirmed that the notation of "ATC-09012022-M-1-WM-U" on page 1 of the Member Handbook indicates the handbook was last revised and submitted to SCDHHS for approval on September 1, 2022.

Members are informed in the Member Handbook that they have a right to receive notice of significant changes in the benefits package at least 30 days before the intended effective date of the change. The Member Handbook also informs that members will be notified if their PCP terminates from the network. Processes for notifying members of provider terminations were addressed in policy; however, ATC staff confirmed there is no policy that defines processes for notifying members of changes in the benefit package.

ATC uses appropriate processes to ensure member materials are understandable and available in alternate formats and languages as needed to meet member needs. Member materials are written at no higher than a 6th grade reading level. The Member Handbook

provides information about the availability of and how to request translated materials and interpreter/language services at no cost.

The Member Services Call Center is available via a toll-free telephone number, toll-free fax, and TTY from 8:00 a.m. to 6:00 p.m., Monday through Friday. Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, defines performance standards for speed of answer, average hold time, and the disconnect rate for incoming calls. However, the *SCDHHS Contract, Section 3.17.17.3*, also specifies a performance standard for the percentage of calls receiving a busy signal. This requirement is not addressed in Policy SC. MBRS.28. ATC staff reported that because the call system is set up to roll calls over to another call center during high call volumes, callers will not receive busy signals. For 2022, the Call Center met or exceeded all goals, as noted in the 2022 QI Program Evaluation.

The Population Health Management Strategy Description: 2022-2023 states ATC uses online, print, digital, and person-to-person communication strategies to engage with members and provide information about programs and services. These strategies include New Member Welcome packets, telephonic outreach, email, automated text messages and calls, newsletters, etc. Additionally, information is disseminated during member inquiries or requests for assistance, through face-to-face visits, and during community events. The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description 2023 includes the goals, objectives, and guidelines for the EPSDT Program. ATC uses various data sources to identify EPSDT eligible members, monitors compliance with the provision of EPSDT services, and conducts outreach to educate and follow-up with members to improve EPSDT screening rates.

Member Satisfaction Survey

ATC contracts with Press Ganey, a certified vendor, to conduct adult and child surveys. For MY2022, the adult response rate was 11.5% (255 out of 2,228), which is an improvement from the previous year's response rate of 10.3%. For year over year trending, the findings showed improvement in the ratings of customer service, coordination of care, rating of specialist., getting care quickly, and rating of personal doctor. The largest decline was in the rating of health care.

The Child response rate was 10.0% (272 out of 2,723 surveys), an increase over the previous year's rate of 7.8%. Improvement occurred for the rating of health plan. The largest decline was in getting care quickly.

The Child with CCC response rate was 9.7% (159 out of 1650), which is an improvement over the previous year's rate of 7.2%. For the CCC population, the rating of health plan,

coordination of care, and the rating of specialist improved from the previous year. The largest decline for the CCC population was related to customer service.

Press Ganey summarizes and details all results from the Adult and Child surveys. The QI Program Evaluation 2022 showed analysis of CAHPS data. The most recent survey results were presented during the Q3 QIC meeting on 8/29/2023.

Grievances

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

Policy SC.MM.11, Member Grievances, ATC's Member Handbook, Provider Manual, and the website provides the definition of a grievance, describes who can and how to file a grievance, and provides instructions for filing a written or verbal grievance. Steps clearly outline how to appoint an authorized representative if needed. Appropriate timeframes are detailed in policy for grievance acknowledgement, extensions if needed, and resolution.

ATC reported onsite that complaints are logged separately by the Compliance Department and are resolved within one calendar day. Of the grievance file sample reviewed for the 2023 EQR, all grievances were resolved timely. Two grievance files discussed onsite contained an acknowledgement letter that exceeded the five-day timeframe indicated in Policy SC.MM.11, Member Grievances. One grievance received on 12/19/22 was closed with sixty days remaining when investigation notes indicate that additional information was needed from the member to resolve the billing grievance reported.

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

Figure 4: Member Services Findings

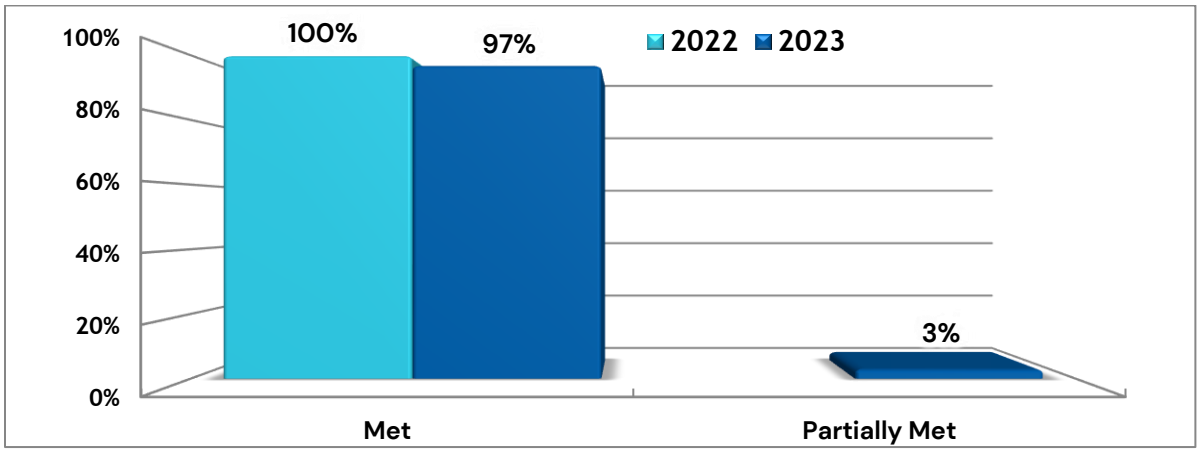


Table 15: Member Services Comparative Data

Section	Standard	2022 Review	2023 Review
Member Rights and Responsibilities	Member rights include, but are not limited to, the right: 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	Met	Partially Met

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

Table 16: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Members are informed of their rights through the Member Handbook, in newsletters, and on ATC's website.	✓		
The Member Handbook is a comprehensive resource for members to understand their benefits as well as health plan services and processes.			✓
ATC ensures member materials are understandable and available in alternate formats as needed to meet member needs.			✓
For 2022, the Call Center met or exceeded all performance goals.	✓		
ATC uses various communication strategies to provide information about programs and services and to encourage members to get recommended preventive services. These include welcome packets, telephonic outreach, email, automated text messages and calls, newsletters, etc.			✓
Member satisfaction results for Child and Adult are examined internally.	✓		
For the 2023 EQR sample of grievance files reviewed, all were resolved timely.		✓	

Table 17: Member Services Weaknesses, Recommendations, and Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy SC.MBRS.25, Member Rights and Responsibilities, does not include the member right 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." Refer to the SCDHHS Contract, Section 3.15.4.6.	Quality Improvement Plan: Revise Policy SC.MBRS.25 to include that members have a right to exercise their rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat members.			✓

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Per the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18, newborn hearing screenings are "included in the Core Benefits when they are rendered to newborns in an inpatient hospital setting." However, the Member Handbook, page 33, only addresses hearing screenings as part of routine EPSDT services.	Recommendation: Revise the Member Handbook to indicate that newborn hearing screenings are covered when conducted in the inpatient setting.			✓
The *SCDHHS Contract, Section 3.12.2.16,* requires the Member Handbook to include the date of the last revision. Onsite discussion confirmed that the notation of "ATC-09012022-M-1-WM-U" on page 1 of the Member Handbook indicates the handbook was last revised and submitted to SCDHHS for approval on September 1, 2022.	Recommendation: Revise the Member Handbook to clearly indicate the date of last revision, as required by the *SCDHHS Contract, Section 3.12.2.16*.	✓		
ATC staff confirmed there is no policy that defines processes for notifying members of changes in the benefit package.	Recommendation: Create a policy to detail the processes and timeframes for notifying members of changes in the benefits package.	✓		
The *SCDHHS Contract, Section 3.17.17.3*, states "No more than two (2) percent of incoming calls shall receive a busy signal per day." This requirement is not addressed in Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance. This was discussed during the onsite, and ATC staff responded that the call system is set up to roll calls over to another call center during high call volumes; therefore, callers will not receive busy signals.	Recommendation: Revise Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, to include information that during high call volumes, calls are routed to additional call centers and members do not receive busy signals.	✓		

III. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. Members Services						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					ATC informs members of their rights and responsibilities through the Member Handbook at enrollment and annually (or when changes occur) in newsletters, the Member Handbook, and ATC's website, as noted in Policy SC.MBRS.25, Member Rights and Responsibilities.
2. Member rights include, but are not limited to, the right:		X				The list of member rights is consistently documented across the Member Handbook, the Provider Manual, and ATC's website. An issue was noted in Policy SC.MBRS.25, Member Rights and Responsibilities. See standard 2.6 below.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						Policy SC.MBRS.25, Member Rights and Responsibilities, does not include the member right 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." Refer to the *SCDHHS Contract, Section 3.15.4.6*. *Quality Improvement Plan: Revise Policy SC.MBRS.25 to include that members have a right to exercise their rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat members.*
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 Benefits and services included and excluded in coverage;						The Member Handbook includes a grid listing benefits that are covered and excluded from coverage and additional information about benefits is found throughout the Member Handbook. The Member Handbook also includes information about additional, non-core benefits provided to ATC members. Per the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18*, newborn hearing screenings are "included in the Core Benefits when they are rendered to newborns in an inpatient hospital setting." However, the Member Handbook, page 33, only addresses hearing screenings as part of routine EPSDT services. *Recommendation: Revise the Member Handbook to indicate that newborn hearing screenings are covered when conducted in the inpatient setting.*
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;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						The Member Handbook includes a grid listing benefits and related copayment amounts, coverage requirements and limitations, and maximum benefits when applicable.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The Member Handbook benefits grid lists general prior authorization requirements. Additional information is found throughout the Member Handbook.
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;						
1.7 Policies and procedures for accessing specialty care;						The Member Handbook informs that PCP referrals are not required for members to seek specialty care from network providers. Members are encouraged to check with their PCP before seeing a specialist so that the PCP can coordinate care and request necessary services.
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						The "Pharmacy" section of the Member Handbook addresses processes for obtaining prescription medications, accessing the Preferred Drug List, locating participating pharmacies, copayments, the limitation on the supply of medications, and prior authorization processes. The "Durable Medical Equipment (DME)" section of the Member Handbook

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						addresses processes for obtaining medical equipment.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						Processes for initial selection of a PCP and changing the assigned PCP are found in the Member Handbook. The role of the PCP, including using the PCP for initial contact for care, is also addressed.
1.11 Procedures for disenrolling from the MCO;						The Member Handbook informs members about the circumstances under which they may request disenrollment without cause and circumstances under which members may request for-cause disenrollment. The handbook also addresses reasons for which the health plan may request member disenrollment.
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;						Members are informed that they may use the "Find a Provider Tool" on ATC's website to search for providers by name, location, or specialty. The Member Handbook lists additional provider information that is available in the online Find a Provider Tool. Members may also contact Member Services to get assistance with locating a provider or to obtain other provider information.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
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;						The Member Handbook provides a listing of services available through the Member Services Department as well as contact information and normal operating hours. Members are also informed of resources available on ATC's website and functions available when using the secure member portal. The Member Handbook addresses the functions of and information available through the Nurse Advice Line.
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						A description of EPSDT services is found in the Member Handbook. The information includes components of EPSDT/well-child visits and the recommended periodicity schedule.
1.20 A description of advance directives, how to formulate an advance directive, and						Information about advance directives is included in the Member Handbook and on ATC's website. The information includes definitions of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
how to receive assistance with executing an advance directive;						terminology, the purpose of advance directives, how to get assistance with formulating advance directives, websites to obtain applicable forms and documents, and how to file a complaint about advance directives not being followed.
1.21 Information on how to report suspected fraud or abuse;						The Member Handbook defines appliable FWA terminology and provides contact information for reporting FWA by mail or email to ATC, by phone to the ATC Faud and Abuse Hotline, and by mail, phone, and email to the SCDHHS Division of Program Integrity.
1.22 Additional information as required by the contract and/or federal regulation;						The *SCDHHS Contract, Section 3.12.2.16*, requires the Member Handbook to include the date of the last revision. Onsite discussion confirmed that the notation of "ATC-09012022-M-1-WM-U" on page 1 of the Member Handbook indicates the handbook was last revised and submitted to SCDHHS for approval on September 1, 2022. *Recommendation: Revise the Member Handbook to clearly indicate the date of last revision, as required by the SCDHHS Contract, Section 3.12.2.16.*
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					As described by ATC staff during onsite discussion, new members are provided with a Member Handbook and informed by letter that they may request a Provider Directory by contacting Member Services or they may access the provider listing on ATC's website. Members are notified annually via newsletters

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and an annual mailing that they may request a Provider Directory and Member Handbook.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					The Member Rights list on page 53 of the Member Handbook indicates it is a member's right to receive notice of significant changes in the benefits package at least 30 days before the intended effective date of the change. Page 15 of the Member Handbook indicates ATC notifies members by letter at least 30 calendar days prior to the effective date if their PCP is no longer in ATC's network. If the PCP gives less than 30 days' notice, ATC notifies affected members as soon as possible, but no later than 15 calendar days after the receipt of the notification. ATC staff confirmed there is no policy that defines processes for notifying members of changes in the benefit package. Policy CC.PRVR.23, Provider Termination Policy, states ATC notifies members of provider terminations at least 30 days before the effective date of the change, or as soon as possible based on the receipt of the notification. More detailed information is found in Policy SC.ELIG.14, Member Notification of Provider Termination, which states members who are affected by a provider's termination are notified by letter at least 30 calendar days prior to the effective date of termination and if the provider's notification of termination is received

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						less than 30 calendar days prior to the effective date, the notification is provided no later than 15 calendar days after receipt of the notification. *Recommendation: Create a policy to detail the processes and timeframes for notifying members of changes in the benefits package.*
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy SC.COMM.19, Member Materials Readability, addresses requirements and processes to ensure member materials are understandable and available in alternate formats as needed to meet member needs. ATC member materials are evaluated for compliance with a 6th grade reading level by using the Flesch-Kincaid method within Microsoft Word. Large font materials will use no less than 18-point font. When at least 5% of the resident population of a county is non-English speaking, and speaks a specific foreign language, foreign language versions of materials are made available in the specific language. ATC makes written materials available in alternate formats and through auxiliary aids and services. The Member Handbook provides information about the availability of translated materials and instructs to contact Member Services. It states member materials are available in large font, paper form, and audio CD at no cost. It also informs members that interpreter services are available at no cost, including sign language.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ATC's language line is available around the clock. The toll-free language line telephone number is provided, and members may also contact Member Services. The South Carolina Relay Services voice and TTY numbers are also included in the Member Handbook.
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					Per Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, the Member Services Call Center is available from 8:00 a.m. to 6:00 p.m., Monday through Friday. As noted in the Member Handbook, the Call Center is available via a toll-free telephone number as well as by toll-free fax and TTY. ATC uses an automated answering system that instructs members to call 911 or go to the nearest emergency room in an emergency. It also allows members to speak directly to a mental health professional or health care provider. Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, defines performance standards as: • Speed of answer – 80% of all calls within 30 seconds or less • Average hold time – 3 minute • Disconnect rate of all incoming calls – 5% The *SCDHHS Contract, Section 3.17.17.3*, states "No more than two (2) percent of incoming calls shall receive a busy signal per day." This requirement is not addressed in Policy SC. MBRS.28. This was discussed during the onsite,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and ATC staff responded that the call system is set up to roll calls over to another call center during high call volumes; therefore, callers will not receive busy signals. *Recommendation: Revise Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, to include information that during high call volumes, calls are routed to additional call centers and members do not receive busy signals.*
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					ATC auto-assigns a PCP when members do not select one or are auto-enrolled into ATC without a PCP. If the member selects a PCP, the PCP assignment is effective immediately, and a new ID card is sent to the member. When auto-assigning a PCP, ATC considers whether there is a PCP available who has a historical relationship with the member and the provider's geographic location to the member (no more than 30 miles). For new members, the PCP assignment is effective on the first of the month of member enrollment with ATC. The processes for PCP assignment are found in Policy SC.ELIG.01, PCP Assignment.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC.ELIG.11, MCO Initiated Disenrollment, defines the reasons for which ATC may request a member's disenrollment and states that all plan-initiated disenrollment requests must be directed to Healthy Connections Choices in

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						writing. The policy notes that "ATC may not request disenrollment because of an adverse change in the enrollee's health status, or because the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs." SCDHHS makes the final decision about member disenrollment. Onsite discussion confirmed that if a member were at risk for disenrollment due to behavior problems that impair ATC's or providers' abilities to furnish services to this member or other members, ATC would engage the Case Management team to work with the member to try to redirect/improve behavior.
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					The Member Handbook states ATC's lifestyle management program and chronic conditions program provides health coaching, health assessment, and an incentive management guide to healthy members to encourage healthy living. These programs include wellness, disease management, episodic/catastrophic care management, work-life resource and referral, employee assistance, and professional training for populations of all types and sizes. The Population Health Management Strategy Description: 2022-2023 states ATC uses online, print, digital, and person-to-person communication strategies to engage with

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members and provide information about programs and services. These strategies include New Member Welcome packets, telephonic outreach, email, automated text messages and calls, newsletters, etc. Additionally, information is disseminated during member inquiries or requests for assistance, through face-to-face visits, and during community events.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description 2023 includes the goals, objectives, and guidelines for the EPSDT Program. It addresses member identification and outreach. As noted in the EPSDT Program Description, ATC uses various data sources, including claims data, encounter data, and pharmacy data, to identify EPSDT eligible members. ATC monitors compliance with the provision of EPSDT services and QI Outreach Teams conduct outreach to educate and follow-up with members to improve EPSDT screening rates.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					The Member Handbook includes information about preventive health services. Members are informed they can view the preventive health guidelines on the health plan's website, or they can contact Member Services to request the information. The Member Handbook also provides information about the disease and care management programs for asthma, diabetes, and high-risk pregnancy.
4. The MCO identifies pregnant members; provides educational information related to	X					The Population Health Management Strategy Description: 2022-2023 indicates the various

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.						ways pregnant members are identified, including but not limited to, claims, community agencies, internal staff, hospital and ER reports, practitioners, member self-reports, and Notification of Pregnancy (NOP) forms. ATC provides all pregnant members with communication that welcomes them and encourages them to complete the NOP form and to seek prenatal care. ATC sends pregnant members a Start Smart for Your Baby brochure, and a NOP form with return envelope. ATC provides educational materials that promote prenatal and postpartum care, newborn care, and healthy habits to members enrolled in the Start Smart for Your Baby Program. The Start Smart for Your Baby Program also includes a person-centered text and email program to provide information, resources, and reminders that are timed to coincide with the member's due date.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					ATC contracts with Press Ganey, a certified vendor, to conduct adult and child surveys. Press Ganey acquired SPH analytics. For MY2022, the adult response rate was 11.5% (255 out of 2,228), which is an improvement from the previous year's response rate of 10.3%. For year over year trending, the findings showed improvement in the ratings of customer service,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						coordination of care, rating of specialist., getting care quickly, and rating of personal doctor. The largest decline was in the rating of health care. The Child response rate was 10.0% (272 out of 2,723 surveys), an increase over the previous year's rate of 7.8%. Improvement occurred for the rating of health plan. The largest decline was in getting care quickly. The Child with CCC response rate was 9.7% (159 out of 1650), which is an improvement over the previous year's rate of 7.2%. For the CCC population, the rating of health plan, coordination of care, and the rating of specialist improved from the previous year. The largest decline for the CCC population was related to customer service.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Press Ganey summarizes and details all results from the Adult and Child surveys. The QI Program Evaluation 2022 showed analysis of CAHPS data.
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					The Quality Improvement Provider Program Information memo showed HEDIS and CAHPS trending rates.
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					Survey results were presented during the Q3 QIC meeting on 8/29/2023
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC.MM.11, Member Grievances, the Member Handbook, Provider Manual, and website clearly describe ATC's processes for filing and resolving grievances.
1.1 The definition of a grievance and who may file a grievance;	X					A grievance is concisely defined as dissatisfaction "… about any matter other than an adverse benefit determination."
1.2 Procedures for filing and handling a grievance;	X					Grievances may be filed verbally or in writing by the member or a member's authorized representative with ATC.
1.3 Timeliness guidelines for resolution of a grievance;	X					Policy SC.MM.11, Member Grievances, describes that grievances will be acknowledged via letter within 5 calendar days of receipt of a grievance.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Standard Grievance resolutions may not exceed 90 calendar days from the day ATC receives the grievances.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.	X					Of the sample file reviewed for the 2023 EQR, all were resolved timely. Two grievance files contained an acknowledgement letter that exceeded the five-day timeframe per policy. One grievance was closed sixty days early when investigation notes indicate that additional information was needed from the member to resolve the billing grievances reported.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Complaints are logged separately by the Compliance Department and are resolved within one calendar day or within one call.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

D. Quality Improvement

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

ATC has developed a Quality Improvement (QI) program that includes all aspects of health care quality. ATC's 2023 Quality Program Description details the program's structure, objectives, scope, and methodology. ATC's primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings. Members and providers are informed of the QI Program via the website, the Member Handbook, and the Provider Manual. Results of select HEDIS measures and CAHPS results are included on the website and members and providers are encouraged to contact the health plan for additional information.

ATC's Board of Directors has authority and oversight of the QI Program and is accountable for the oversight of the quality of care and services provided to members. This board has delegated the operating authority to the Quality Improvement Committee (QIC). ATC's Chief Medical Officer is the Senior Quality Executive responsible for monitoring and directing all quality activities. The Behavioral Health Medical Director is responsible for the behavioral health aspects of the QI Program. Meetings of the QIC are chaired by the Chief Medical Officer. Voting members include senior health plan staff and participating network practitioners. The network practitioners who serve as voting members of the QIC specialize in Family Medicine, OB/GYN, Pediatrics, and Psychiatry. A quorum is defined as a minimum of three committee members, including the committee chair, one health plan staff, and one external practitioner. The Committee Chair is the determining vote in case of a tie.

The QIC meets at least quarterly with additional meetings scheduled as needed. The committee meeting minutes demonstrated this committee met the meeting frequency and quorum requirements.

Annually, ATC develops a QI work plan to identify the planned activities related to program priorities. The Work Plan reflects the ongoing progress of the quality activities that are reported to the QIC on a quarterly basis. The 2022 and 2023 Work Plans were submitted for review. Both Work Plans included the scope and/or activity, a description of the activity, responsible party, timeframe for completion, and the results or status.

The QI Program Description describes the Preventive Health Reminder Program. The program's aim is to improve the adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. This program uses various member and provider interventions and activities to improve access to these services and member compliance. Examples include member and provider education, targeted telephonic digital

and/or written outreach to members, and targeted communications to providers identifying members who are due or overdue for preventive health screenings. There was no program description or policy that outlined the specifics for tracking and monitoring adherence to the Preventive Health Program.

ATC's EPSDT Program serves members from birth through the month of their 21st birthday. This program is designed to ensure members are aware of the EPSDT requirements that include access to required screenings and necessary treatment services. The QI Outreach Team conducts education and outreach to members and providers to improve overall screening rates.

An assessment of the effectiveness of the QI program for the year is prepared annually. ATC's 2022 Quality Improvement Program Evaluation provided a systematic analysis of ATC's performance of the QI activities and evaluated the overall effectiveness of the program.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation Quality Health conducted a validation review of the HEDIS measures following the CMS protocol. 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 (PMs) for the current measure year (2022), the previous measure year (2021), and the change from 2021 to 2022 are reported in *Table 18: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial improvement (>10%) and the rates shown in red indicate a substantial decline (>10%).

Table 18: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	65.94%	73.48%	7.54%
Counseling for Nutrition	59.12%	61.80%	2.68%
Counseling for Physical Activity	53.77%	57.42%	3.65%
Childhood Immunization Status (cis)			

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
DTaP	64.23%	65.21%	0.98%
IPV	79.56%	82.97%	3.41%
MMR	81.51%	82.97%	1.46%
HiB	73.97%	80.05%	6.08%
Hepatitis B	77.13%	82.00%	4.87%
VZV	81.02%	82.73%	1.71%
Pneumococcal Conjugate	66.91%	69.83%	2.92%
Hepatitis A	78.35%	83.21%	4.86%
Rotavirus	64.48%	70.07%	5.59%
Influenza	37.71%	30.17%	-7.54%
Combination #3	57.18%	59.61%	2.43%
Combination #7	50.12%	53.53%	3.41%
Combination #10	27.01%	21.41%	-5.60%
Immunizations for Adolescents (ima)			
Meningococcal	72.26%	70.07%	-2.19%
Tdap/Td	81.75%	83.70%	1.95%
Combination #1	72.02%	70.07%	-1.95%
Combination #2	33.82%	29.93%	-3.89%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	34.79%	30.17%	-4.62%
Lead Screening in Children (lsc)	63.79%	60.30%	-3.49%
Breast Cancer Screening (bcs)	54.62%	52.18%	-2.44%
Cervical Cancer Screening (ccs)	61.8%	56.93%	-4.87%
Colorectal Cancer Screening (COL)	NR	36.77%	NA
Chlamydia Screening in Women (chl)			
Total	61.77%	61.17%	-0.60%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	74.17%	80.32%	6.15%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	22.49%	22.83%	0.34%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	68.83%	70.16%	1.33%
Bronchodilator	80.97%	79.76%	-1.21%
Asthma Medication Ratio (amr)			
Total	68.39%	62.17%	-6.22%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	42.82%	56.69%	13.87%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	79.07%	75.34%	-3.73%

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - Total	79.5%	80.18%	0.68%
Statin Adherence 80% - Total	59.11%	57.64%	-1.47%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	2.05%	3.10%	1.05%
Cardiac Rehabilitation - Engagement1 (Total)	2.46%	5.75%	3.29%
Cardiac Rehabilitation - Engagement2 (Total)	0.82%	5.75%	4.93%
Cardiac Rehabilitation - Achievement (Total)	0.00%	2.65%	2.65%
Effectiveness of Care: Diabetes			
Hemoglobin A1c Control for Patients With Diabetes (hbd)			
HbA1c Poor Control (>9.0%)	37.23%	39.66%	2.43%
HbA1c Control (<8.0%)	52.8%	51.82%	-0.98%
Eye Exam (Retinal) Performed	48.42%	42.34%	-6.08%
Blood Pressure Control (<140/90 mm Hg)	50.36%	56.69%	6.33%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (Total)	23.56%	25.81%	2.25%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	65.82%	63.26%	-2.56%
Statin Adherence 80%	59.5%	51.65%	-7.85%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (dmh)			
Diagnosed Mental Health Disorders (Total)	NR	23.06%	NA
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	51.59%	45.03%	-6.56%
Effective Continuation Phase Treatment	35.89%	28.59%	-7.30%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	37.55%	46.10%	8.55%
Continuation and Maintenance (C&M) Phase	53.78%	59.91%	6.13%
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total - 30-Day Follow-Up	59.23%	62.96%	3.73%
Total - 7-Day Follow-Up	37.59%	42.41%	4.82%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Total - 30-Day Follow-Up	51.2%	52.76%	1.56%
Total - 7-Day Follow-Up	39.45%	40.56%	1.11%
Diagnosed Substance Use Disorders (DSU)			
Diagnosed Substance Use Disorders - Alcohol (Total)	NR	1.76%	NA
Diagnosed Substance Use Disorders - Opioid (Total)	NR	1.46%	NA
Diagnosed Substance Use Disorders - Other (Total)	NR	2.93%	NA

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Diagnosed Substance Use Disorders - Any (Total)	NR	4.89%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Total - 30-Day Follow-Up	31.23%	34.97%	3.74%
Total - 7-Day Follow-Up	17.03%	21.39%	4.36%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
30-Day Follow-Up: Total	12.33%	26.07%	13.74%
7-Day Follow-Up: Total	8.17%	17.38%	9.21%
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (Total)	41.03%	35.31%	-5.72%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	76.8%	75.76%	-1.04%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	68.39%	67.59%	-0.80%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA*	80.00%*	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	60.64%	64.36%	3.72%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - Total	49.36%	51.71%	2.35%
Cholesterol Testing - Total	33.01%	30.23%	-2.78%
Blood glucose and Cholesterol Testing - Total	31.09%	28.14%	-2.95%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.34%	0.75%	-0.59%
Appropriate Treatment for Children With URI (uri)			
Total	87.80%	87.90%	0.10%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	54.37%	56.45%	2.08%
Use of Imaging Studies for Low Back Pain (lbp)	69.95%	69.37%	-0.58%
Use of Opioids at High Dosage (hdo)	2.18%	3.82%	1.64%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	15.8%	17.38%	1.58%
Multiple Pharmacies	1.08%	1.24%	0.16%
Multiple Prescribers and Multiple Pharmacies	0.62%	1.01%	0.39%
Risk of Continued Opioid Use (cou)			
Total - >=15 Days covered	3.72%	3.58%	-0.14%
Total - >=31 Days covered	2.42%	2.12%	-0.30%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
Total	78.18%	72.46%	-5.72%
Initiation and Engagement of AOD Dependence Treatment (iet)			

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Initiation of AOD Treatment: Total	43.41%	42.34%	-1.07%
Engagement of AOD Treatment: Total	10.99%	10.67%	-0.32%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	85.64%	84.43%	-1.21%
Postpartum Care	69.83%	71.29%	1.46%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	61.2%	58.97%	-2.23%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	55.64%	53.35%	-2.29%
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	68.65%	65.07%	-3.58%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	45.12%	41.67%	-3.45%

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

ATC uses a certified software organization for calculation of HEDIS rates. Rates were audited by Healthcare Data Company, LLC. Rates were reviewed for substantial (>10%) changes in rates from last year to this year. There were no rates with a substantial decline. Two rates showed substantial improvement: 30-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) improved 13.74% and Controlling High Blood Pressure improved 13.87%.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

For this review, ATC submitted two PIPs for validation. Topics for those PIPs included Hospital Readmissions and Adult Access to Preventive Health Care. Both PIPs scored in the

"High Confidence in Reported Results" range as noted in tables that follow. A summary of each PIP's status and interventions is also included.

Table 19: Hospital Readmissions PIP

Hospital Readmissions	
The Hospital Readmissions PIP aims to reduce annual rate of readmissions within 30 days for 18 to 64 year old patients. This PIP has three measurement periods. The baseline rate for number of hospital readmissions that occur within 30 days of an inpatient discharge was 18.0%, which reduced to 16.2% in 2021, then 15.5% in 2022. The rate has met the benchmark.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% 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 readmissions. • 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. • 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. • 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. • 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.	

Table 20: Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The PIP showed improvement in the rate from MY2020 at 77.28% to MY2021 at 78.18%. The benchmark is 81.97%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Adult Access to Preventive Health Care (AAP)
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well-versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • Eliza application for scheduling appointments and member outreach. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. • Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.

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

All standards in the Quality Improvement section of this EQR received a "Met" score as shown in *Figure 5: Quality Improvement Findings*.

Figure 5: Quality Improvement Findings

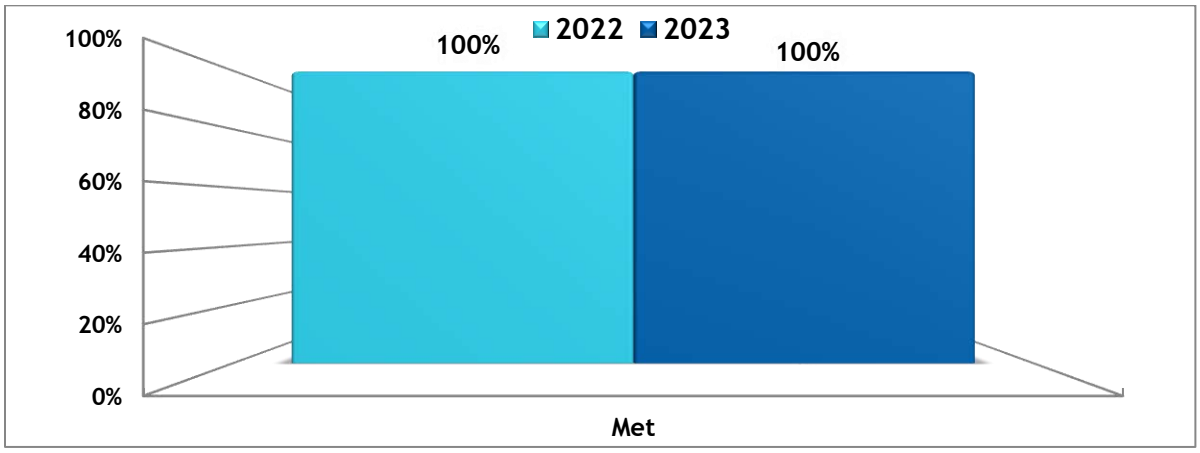


Table 21: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The 2023 Quality Program Description and the 2022 Quality Improvement Program Evaluation were detailed and contained a description, review, and results of all aspects of the program.	✓		
The PIPs met the validation requirements and received scores within the High Confidence range.	✓		
The following HEDIS MY 2022 measure rates had a greater than 10 percentage point improvement: • 30-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) improved 13.74% • Controlling High Blood Pressure improved 13.87%.	✓		

Table 22: QI Weaknesses, Recommendations, and Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
There was no program description or policy that outlines the specifics for tracking and monitoring adherence to the Preventive Health Program.	Recommendation: Develop a program description or a policy that addresses the process used by ATC to track and monitor provider and member adherence to the Preventive Health Program.	✓		

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					ATC has developed a QI program that includes all aspects of health care quality. ATC's 2023 Quality Program Description details the program's structure, objectives, scope, and methodology. ATC's primary goal is to improve members' health status through a variety of meaningful quality improvement activities implemented across all care settings. Members and Providers are informed of the QI Program via the website, the Member Handbook, and the Provider Manual. Results of select HEDIS measures and CAHPS results are included on the website and members and providers are encouraged to contact the health plan for additional information. ATC's Chief Medical Officer is the Senior Quality Executive responsible for monitoring and directing all quality activities. The Behavioral Health Medical Director is responsible for the behavioral health aspects of the QI Program.
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					ATC's Medical Management Department is responsible for identifying potential over and underutilization and quality concerns through review of reports/data such as precertification, concurrent review, readmission reports, member input, assessing member needs, outpatient/inpatient reports,

Standard	SCORE					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pharmacy, case management, sentinel event review, and disease management. Policy SC.UM.02, Monitoring Utilization, provides an overview of the process followed for monitoring potential over and underutilization.
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					Annually, ATC develops a QI work plan to identify the planned activities related to program priorities. The work plan reflects the ongoing progress of the quality activities that are reported to the QIC on a quarterly basis. The 2022 and 2023 Work Plans were submitted for review. Both work plans included the scope and/or activity, a description of the activity, responsible party, timeframe for completion, and the results or status.
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 Board of Directors has authority and oversight of the QI Program and is accountable for oversight of the quality of care and services provided to members. This board has delegated the operating authority to the Quality Improvement Committee. The QIC serves as the umbrella committee through which all subcommittee activities are reported and approved.
2. The composition of the QI Committee reflects the membership required by the contract.	X					Meetings of the QIC are chaired by the Chief Medical Officer. Voting members include senior health plan staff and participating network practitioners. The network practitioners serving as voting members of the QIC specialize in Family Medicine, OB/GYN, Pediatrics, and Psychiatry.

Standard	SCORE					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A quorum is defined as a minimum of three committee members including the committee chair, one health plan staff and one external practitioner. The Committee Chair is the determining vote in case of a tie.
3. The QI Committee meets at regular quarterly intervals.	X					The QIC meets at least quarterly with additional meetings scheduled as needed. The committee meeting minutes demonstrated this committee met the meeting frequency and quorum requirements.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting. These minutes reflect the committee's decisions, actions, and any follow-up needed. Minutes are reviewed and approved at the next regularly scheduled meeting.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					ATC uses a certified software organization for calculation of HEDIS rates. Rates were audited by Healthcare Data Company, LLC. Rates were reviewed for substantial (>10%) changes in rates from last year to this year. There were no rates with a substantial decline. Two rates showed substantial improvement: 30-Day Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua) improved 13.74% and Controlling High Blood Pressure improved 13.87%.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two PIPs were submitted for validation. Topics included: Hospital Readmissions, and Adult Access to Preventive Health Care. The Hospital Readmissions PIP has three measurement periods. The baseline

Standard	SCORE					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						rate for hospital readmissions that occur within 30 days of an inpatient discharge was 18.0%, which reduced to 16.2% in 2021, then 15.5% in 2022. The rate met the benchmark. Interventions include follow-up appointment scheduling, member outreach for medication reconciliation, case management referrals, FindHelp referral resource, provider education, housing review, and data monitoring. The Adult Access to Preventive Health Care PIP showed improvement in the rate from MY2020 at 77.28% to MY2021 at 78.18%. The benchmark is 81.97%. Interventions include staff education, member education, Eliza application for scheduling, and member calls outreach.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					Both PIPs met all the validation requirements and received a validation score withing the High Confidence in Reported Results range.
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					Centelligence provides internal monitoring processes including provider practice patterns, clinical quality, and cost reporting information. This analytic and reporting tool allows ATC to report on all data sets in the platform, including HEDIS, at the individual member, provider, and population levels.

Standard	SCORE					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO tracks provider compliance with						
3.1 Administering required immunizations;	X					The QI Program Description describes the Preventive Health Reminder Program. This program's aim is to improve the adherence to recommended preventive health guidelines for examinations, screening tests, and immunizations. This program uses various member and provider interventions and activities to improve access to these services and member compliance. Examples include member and provider education, targeted telephonic digital and/or written outreach to members, and targeted communications to providers identifying members who are due or overdue for preventive health screenings. There was no program description or policy that outlined the specifics for tracking and monitoring adherence to the Preventive Health Program. *Recommendation: Develop a program description or a policy that addresses the process used by ATC to track and monitor provider and member adherence to the Preventive Health Program.*
3.2 performing EPSDTs/Well Child Visits.	X					ATC's EPSDT Program serves members from birth through the month of their 21st birthday. This program is designed to ensure members are aware of the EPSDT requirements that includes access to required screenings and necessary treatment services. The QI Outreach Team conducts education and outreach to members and providers to improve overall screening rates.

Standard	SCORE					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					ATC's 2022 Quality Improvement Program Evaluation provided a systematic analysis of ATC's performance of the QI activities and evaluated the overall effectiveness of the program.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

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 various program descriptions and policies that outline the overall structure, lines of responsibility, and accountability for the health plan's UM Program for physical health, behavioral health, and pharmacy services. Centene Advanced Behavioral Health is integrated within the UM Program and provides management of behavioral health services for members. Centene Pharmacy Services is the pharmacy benefit manager for ATC and manages all pharmaceutical services for health plan members. Additionally, CVS Caremark provides claims processing for Centene Pharmacy Services.

The Medical Director provides overall oversight of the UM program, and responsibilities include serving as committee chair, conducting consultations, policy development, conducting second level reviews, etc. The Behavioral Health Director provides monitoring and management of all behavioral health care aspects of the UM program. The Pharmacy Director provides clinical oversight of the pharmacy program and conducts policy review, performs second level reviews, serves as liaison between the pharmacy and other departments, etc.

Coverage and Authorization of Services

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

ATC's UM reviewers are licensed clinicians that utilize various evidence-based criteria and guidelines such as InterQual, American Society of Addiction Medicine, individual member circumstances, etc. to make initial clinical determinations. Level II medical necessity reviews are conducted as needed by a Medical Director or licensed practitioner with appropriate clinical expertise.

Standard authorizations are processed within fourteen calendar days and urgent preservice requests are processed within three calendar days. However, there were inconsistencies identified regarding the timeframe for providers to notify ATC for a service authorization request. Policy SC.UM.01, UM Program Description, states that a practitioner must notify ATC within ten calendar days for prior authorization requests; however, Policy CC.UM.05, Timeliness of UM Decisions, states that a provider must submit a prior authorization request within five business days. During onsite discussion, ATC was unable to identify the correct timeframe requirement for providers to notify ATC for a prior authorization request.

Annually, ATC conducts Inter-Rater Reliability (IRR) testing for physicians and UM reviewers. Review of the scores yielded that most of the staff met the target goal of 90%. However, UM reviewers that did not receive a passing score received additional coaching and oversight by the Learning and Development trainers. After coaching and retesting, all UM reviewers passed the IRR testing except one who was placed on a corrective action plan until passing the IRR test.

Policy SC.UM.54, Preferred Provider Designation, describes the health plan's preferred provider process; however, during onsite discussion, ATC was unable to sufficiently describe their Preferred Provider Designation process. During the onsite, ATC stated that once a provider obtains Preferred Provider status that it is communicated to the provider; however, the health plan was unable to describe the process for identification and tracking preferred provider status. ATC also does not have a process for making providers aware of the program.

The Provider Manual, Member Handbook, and various policies outline the role of the Pharmacy and Therapeutic committee and the Preferred Drug List (PDL) process. Policy CC.PHAR.09, Attachment SC Addendum, states new members are allowed to receive PDL medications for 30 calendar days and 60 calendar days for mental health medications. However, the Provider Manual described that new members would be allowed an initial 30 calendar days and an additional 90 calendar days to fill prescription medications. The timeline discrepancy was discussed during the onsite and ATC shared that the health plan was able to honor the original timeline standards with permission from the SCDHHS; however, ATC will honor up to 90 days for new members to fill their prescriptions.

Constellation Quality Health's review of a sample of approval files demonstrated that the approval decisions were made by appropriately licensed healthcare professionals and were communicated according to contractual requirements. Also, ATC maintained or exceeded the monthly target goal for processing prior authorization requests in a timely manner.

Review of a sample of denial files reflected that additional clinical information was requested appropriately prior to making an adverse benefit determination. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, there were four sample denial files wherein the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request. This is no longer a contractual requirement. During onsite discussion, ATC reported they conducted a compliance audit in June 2023 and ensured that the verbiage was removed.

Appeals

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

Policy SC.MM.13, Member Appeals, the Member Handbook, Provider Manual, and website describe processes for filing an appeal. Appeals are appropriately defined as a request to review an "…adverse benefit determination." Appeals may be filed by a member, their authorized representative, or a provider on behalf of the member. Appeals are categorized with trends reported quarterly to the Utilization Management Committee as reflected in committee materials.

Of the sample of appeal files selected for review, ATC's processes were followed according to contractual standards and policies. All sample appeal files were acknowledged, extended with appropriate notification, and resolved timely. Investigation notes and communication to members and providers were detailed, with appropriately credentialed reviewers clearly indicated.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

ATC's process and guidelines for providing care management, disease management, and transition of care management to members are outlined in various program descriptions and policies. ATC members are identified and referred for case management services through several referral sources such as claims data, health providers, interdepartmental referrals, community service organizations, etc. The Care Management Member Prioritization Report, screening tool results, and care management clinical judgement aid to assign members to an appropriate risk stratification level. Also, based upon the results of the health screening tool, members that are identified as poor health and specific population health categories are flagged as high priority referrals.

Once a member is referred as a potential candidate for care management services, outreach is initiated within 30 days and members with more identified urgent needs are contacted sooner depending on the member's priority and risk level. After assessment completion, members are provided care management activities based upon levels such as: care coordination, that entails monitoring and referrals to community resources, care management for members that require moderate level of support based upon their physical and behavioral health needs, and complex case management for members with high complex needs.

ATC provides an integrated care management model for members that encompasses an assigned primary care manager with a collaborative team of physicians, clinical staff, and

non-clinical staff to ensure appropriate care management activities are conducted. Targeted Case Management Services are also provided for special population members. Also, during onsite discussion, ATC described several special programs that were recently developed to address suicide prevention, gaps in medication adherence for minority members, and homelessness and unstable housing needs.

The transition of care process is outlined in various polices. Also, two policies state that members are made aware of the transition of care process through member materials, the Member Handbook, and the website. However, the transition of care process is not described in the Member Handbook. Additionally, there was no verbiage identified within policy or program descriptions that addressed that the health plan assists new members with requesting copies of their medical records from treatment providers.

Review of a sample of care management files demonstrated that care management activities were conducted as required, including conducting care management assessments, treatment planning, follow up, and linkage to appropriate community resources.

As displayed in *Figure 6: Utilization Management Findings*, ATC achieved scores of "Met" for 93% of the Utilization Management standards. Three standards were scored as "Partially Met," as noted in *Table 23: Utilization Management Comparative Data*.

Figure 6: Utilization Management Findings

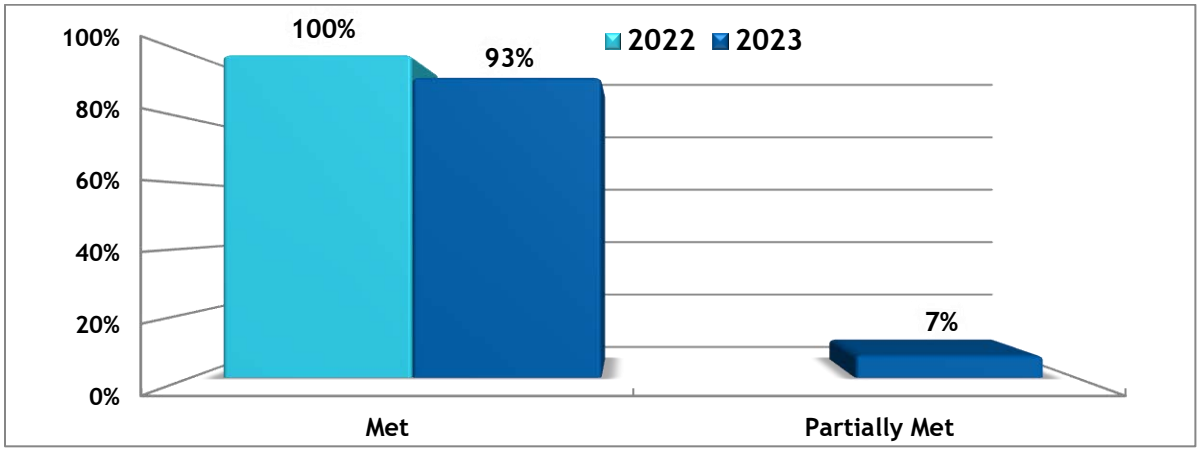


Table 23: Utilization Management Comparative Data

Section	Standard	2022 review	2023 review
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
	the mechanism to provide for a preferred provider program	Met	Partially Met
Medical Necessity Determinations	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Partially Met

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

Table 24: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
ATC maintained a monthly goal of 97% or higher, exceeding the goal of 95%, in processing service authorization requests in a timely manner.		✓	
ATC recently developed a program, Choosing Tomorrow, to address suicide prevention for members.	✓		
A Housing Coordinator position was recently established to aid in addressing homelessness and unstable housing for members.	✓		
ATC developed program initiatives to address the disparity of medication adherence for minority members that entails outreach and education.			✓
For the 2023 EQR sample of appeal files reviewed, all were acknowledged, extended if needed, and resolved timely.		✓	

Table 25: UM Weaknesses, Recommendations and Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy SC.UM.01, UM Program Description, states that practitioners must notify ATC	Quality Improvement Plan: Identify the correct timeframe for providers to submit	✓		

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
within ten calendar days for prior authorization requests; however, Policy CC.UM.05, Timeliness of UM Decisions, states the timeframe of within five business days for providers to provide notification of an authorization request.	prior authorization requests and ensure that the timeframe is consistent within the policy and program description.			
Policy SC.UM.54, Preferred Provider Designation, provides an overview of the Preferred Provider process. However, during onsite discussion, ATC was unable to sufficiently describe the Preferred Provider Designation process. ATC stated that once a provider obtains Preferred Provider status, it is communicated to the provider; however, ATC was unable to describe the process for identification and tracking preferred provider status. Also, ATC was not able to describe the health plan's process for making providers aware of the program.	Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the *SCDHHS Contract, Section 8.5.2.8* and outlined in Policy SC.UM.54, Preferred Provider Designation, with a process of making providers aware of the program.	✓		
There were four sample denial files wherein the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request.	Quality Improvement Plan: Ensure to remove from adverse benefit notices that a written appeal request is required when an oral request is submitted.	✓		
Policy CC.UM.20, Continuity and Coordination of Services, and Policy CC.CM.02, Care Coordination Care Management Services, state that members are made aware of the transition of care process through member materials, the Member Handbook, and website. However, there is no information provided in the Member Handbook that references the transition of care process.	Recommendation: Please provide an outline of the transition of care process in your Member Handbook.	✓		
There was no verbiage provided in policy or program description that addresses that the health plan assists new members with requesting copies of their medical records from treatment providers.	Recommendation: Address in policy that the health plan assists new members with requesting copies of their medical records from treatment providers as required per *SCDHHS Contract Section 5.6.3.*	✓		

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					Policy SC.UM.01, UM Program Description, and various policies outline the overall structure, lines of responsibility, and accountability for ATC's UM Program for physical health, behavioral health, and pharmacy services. Centene Pharmacy Services is the pharmacy benefit manager for ATC and manages all pharmaceutical services for the health plan members. Additionally, CVS Caremark provides claims processing for Centene Pharmacy Services. Centene Advanced Behavioral Health is integrated within the UM Program and provides management of behavioral health services for members. Care management and disease management programs are also offered to ATC members as described in Policy SC.PHCO.01, Population Health and Clinical Management: Care/Case Management.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					ATC's process for conducting medical necessity reviews entails ensuring that the services requested are consistent with the presenting diagnosis, compatible with acceptable practices, and based upon approved evidenced based guidelines as described in Policy SC.UM.01, UM Program Description. Level I medical necessity

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviews are conducted by a licensed UM clinician and Level II medical necessity reviews are conducted as needed by a Medical Director or licensed practitioner with an appropriate clinical expertise.
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				Policy CC.UM.05, Timeliness UM Decisions and Notifications, states standard authorizations are processed within fourteen calendar days and urgent preservice requests are processed within three calendar days. However, there were inconsistencies identified regarding the timeframe for providers to notify ATC for a service authorization request. Policy SC.UM.01, UM Program Description, states that a practitioner must notify ATC within ten calendar days for prior authorization requests; however, Policy CC.UM.05, Timeliness of UM Decisions, states the timeframe is within five business days. During onsite discussion, ATC was unable to clarify the correct timeframe requirement for provider submissions of prior authorization requests. *Quality Improvement Plan: Please identify the correct timeframe for providers to submit prior authorization requests and ensure that the timeframe is consistent within your policy and program description.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Policy SC.UM.01, UM Program Description, and Policy, CC.UM.04, Appropriate UM Professionals, state that all individuals involved in the UM decision making process sign an "Affirmative Statement About Incentives" acknowledging that UM decisions are based solely on the appropriateness of care.
1.7 the mechanism to provide for a preferred provider program.		X				Policy SC.UM.54, Preferred Provider Designation, provides an overview of their Preferred Provider process. However, during onsite discussion, ATC was unable to sufficiently describe the Preferred Provider Designation process. ATC stated that once a provider obtains Preferred Provider status that it is communicated to the provider; however, ATC was unable to describe their process for identification and tracking preferred provider status. Also, ATC was not able to describe the health plan's process for making providers aware of the program. *Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy SC.UM.54, Preferred Provider Designation, with a process for making providers aware of the program.*
2. Utilization management activities occur within significant oversight by the Medical	X					Policy SC.UM.01, UM Program Description, and Policy CC.PHAR.09, Pharmacy Program Description, provide a descriptive overview of the roles and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
Director or the Medical Director's physician designee.						responsibilities of the Medical Director, Behavioral Health Director, and Pharmacy Director. The Medical Director provides overall oversight of the UM program, and responsibilities include serving as committee chair, conducting consultations, policy development, conducting second level reviews, etc. The Behavioral Health Director provides monitoring and management of all behavioral health care aspects of ATC's UM program. The Pharmacy Director provides clinical oversight of the pharmacy program and conducts policy review, performs second level reviews, serves as liaison between the pharmacy and other departments, etc.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
V B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					ATC's UM reviewers utilize evidence-based criteria and guidelines such as InterQual, American Society of Addiction Medicine, individual member circumstances, etc. in performing clinical determinations as described in Policy SC.UM.01, UM Program Description, and Policy CC.PHAR.09, Pharmacy Program.

Standard	Score					Comments
	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					
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The process and requirements for covering hysterectomies, sterilizations, and abortions are described in Policy SC.UM.33, Abortions, Policy SC.UM.45, Sterilizations and Hysterectomies, the Member Handbook, and the Provider Manual. Policy SC.UM.33, Abortions, identifies that therapeutic abortions require prior authorization. Hysterectomies and sterilizations do not require a plan authorization; however, appropriate consent is required as described in Policy SC.UM.45, Sterilizations and Hysterectomies.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Annually, ATC conducts Inter-Rater Reliability (IRR) testing for physicians and UM reviewers. Most staff met the target goal of 90%. However, the UM reviewers that did not receive a passing score received additional coaching and oversight by the Learning and Development trainers. After coaching and retesting, all UM reviewers passed the IRR testing except one who was placed on a corrective action plan until passing the IRR test. During onsite discussion, ATC described that the corrective action plan entailed increased individualized supervision, completion of specific modules, and practice review of live cases.

Standard	Score					Comments
	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					The Provider Manual, Member Handbook, and various policies outline the role of the Pharmacy and Therapeutics Committee and the Preferred Drug List (PDL) process. Policy CC.PHAR.09, Attachment SC Addendum, states that new members are allowed to receive PDL medications for 30 calendar days and 60 calendar days for mental health medications. However, the Provider Manual described that new members would be allowed an initial 30 calendar days and an additional 90 calendar days to fill prescription medications. The timeline discrepancy was discussed, and ATC shared that the previous 30 and 60 day timeframes were the original timeframe for new members to receive medications. However, the timeframe was updated to an additional 90 days, but ATC was allowed to maintain the original timeline standards per SCDHHS. ATC shared the health plan will honor up to 90 days for new members to fill their prescriptions.
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
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Review of a sample of approval files reflected that the UM determinations were made by appropriately licensed healthcare professionals as outlined in Policy CC.UM.04, Appropriate UM Professionals.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Constellation Quality Health's review of the sample of approval files demonstrated that the approval decisions were communicated according to contractual requirements for standard and expedited requests. Also, ATC maintained a 97% or higher monthly goal, exceeding the goal of 95%, in processing service authorization requests in a timely manner.
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					Constellation Quality Health's review of a sample of denial files reflected that additional clinical information was requested appropriately prior to making an adverse benefit determination.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the		X				Constellation Quality Health's review of a sample of denial decisions demonstrated that adverse benefit determinations were promptly communicated to the provider and member.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
denial of service and the procedure for appeal.						Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, in four sample denial files, the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request. This is no longer a contractual requirement. During onsite discussion, ATC reported they conducted a compliance audit in June 2023 and ensured that the verbiage was removed. *Quality Improvement Plan: Remove from adverse benefit determination notices that a written appeal request is required when an oral request is submitted.*
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC.MM.13, Member Appeals, the Provider Manual, Member Handbook, and ATC's website describe processes for resolving members' requests to reconsider an adverse benefit determination.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					An appeal is consistently defined as "A request for review of an action, as adverse benefit determination."
1.2 The procedure for filing an appeal;	X					Processes are clearly described for filing an appeal verbally or in writing and are outlined for members, their authorized representative, or providers.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy, SC.MM.13, Member Appeals, provides appropriate timelines for filing, acknowledgment, extensions if needed, and resolution of appeals.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Of the appeals files sampled for the 2023 EQR, all were acknowledged and resolved timely.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeal logs are appropriately categorized per the contractual guidelines. Trends are reported quarterly to the Utilization Management Committee.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					Policy SC.PHCO.01, Population Health and Clinical Management: Care/Case Management, Policy SC.UM SC.UM.41, Transition of Care, and additional policies describe ATC's process and guidelines for providing care management, disease management, and transition of care services to members.
2. The MCO has processes to identify members who may benefit from care management.	X					As described in Policy CC.CM.02, Care Coordination/Care Management Services, ATC members are identified and referred for case management services through several sources such as claims data, health providers, interdepartmental referrals, community service organizations, etc. Also, based upon the results of the health screening tool, members identified as poor health and specific population health categories are flagged as high priority referrals. The Care Management Member Prioritization Report, screening tool results, and care management clinical judgement aid in assigning members to an appropriate risk stratification level of low priority, moderate priority, and high priority.
3. The MCO provides care management activities based on the member's risk stratification.	X					Once a member is referred as a potential candidate for care management services, outreach is initiated within 30 days and members with more identified urgent needs are contacted sooner depending on the priority and risk level. After assessment completion, members are stratified based upon their risk level and provided care management activities based upon levels such as: care coordination that entails monitoring and referrals to community resources, care management for members that require a moderate

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						level of support based upon their physical and behavioral health needs, and complex case management for members with high complex needs.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					ATC provides an integrated care management model for health plan members. Members are assigned a primary care manager that works with a collaborative team of physicians, clinical staff, and non-clinical staff to ensure that comprehensive care management activities are provided to members as described in Policy SC.PHCO.CM.01, Care Management Program Description. Targeted Case Management Services are also provided for special population members such as children that are in foster care, adults in need of Adult Protective Services, individuals with intellectual disabilities, etc. During onsite discussion, ATC described several programs that were recently developed such Choosing Tomorrow to address suicide prevention and Housing Coordination to address homelessness and unstable housing. ATC also developed program initiatives to address the disparity of medication adherence for minority members that entails outreach and education.
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					
6. Care Transitions activities include all contractually required components.						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					Various policies outline the transition of care process. Also, Policy CC.UM.20, Continuity and Coordination of Services, and Policy CC.CM.02, Care Coordination Care Management Services, state that members are made aware of the transition of care process through member materials, the Member Handbook, and the website. However, there is no information provided in the Member Handbook that references the transition of care process. Post onsite, ATC submitted a redlined version of the Member Handbook that describes the transition of care process. *Recommendation: Provide an outline of the transition of care process in the Member Handbook.* Also, there was no verbiage provided in policy or program description that addresses that the health plan assists new members with requesting copies of their medical records from treatment providers. *Recommendation: Address within a policy that the health plan assists new members with requesting copies of their medical records from treatment providers, as required per SCDHHS Contract, Section 5.6.3.*
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					
8. Care management and coordination activities are conducted as required.	X					Review of a sample of care management files reflected that care management activities were conducted as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

F. Delegation

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

ATC delegates to subcontractors and/or vendors to perform some health plan activities. Those activities include case management, utilization management, network management, and credentialing.

For this review, ATC reported 23 delegation agreements, as shown in *Table 26: Delegated Entities and Services*.

Table 26: Delegated Entities and Services

Delegated Entities	Delegated Services
• CareCentrix	Case Management Claims/Payments Credentialing – Facilities Network Management Utilization Management
• CVS	Pharmacy Standards (Claims, Credentialing, Network Management)
• Envolve Vision	Claims/Payments Provider Payment Appeals Credentialing – Practitioners Utilization Management
• Express Scripts	Medication Therapy Management Pharmacy Services – Claims, Credentialing, Network Management
• Medical Review Institute of America	Utilization Management Utilization Management – Member Appeals
• ModivCare	Transportation Standards
• National Imaging Associates	Customer Service Utilization Management Utilization Management – Member Appeals
• New Century Health	Utilization Management
• TurningPoint Healthcare Solutions	Customer Service Utilization Management Utilization Management – Member Appeals
• AU Medical Center • Bon Secours St. Frances Physician Services • United Physicians • Preferred Care of Aiken • CVS Health Minute Clinic	Credentialing and recredentialing

Delegated Entities	Delegated Services
• Self Regional Health Care • Prisma Palmetto USC • AnMed Health • Lexington Medical Center • Regional Health Plus Spartanburg • Roper St. Francis Physicians Network • Health Network Solutions • Management and Network Services, LLC • Medical University of South Carolina	

All delegated functions are governed by an agreement that outlines the scope of activities to be performed, performance expectations, and the monitoring process. Policy CC.QI.14, Oversight of Delegated Activities, describes the processes for oversight and monitoring of delegated entities. Prior to delegation, ATC conducts an evaluation of the potential delegate by conducting a pre-delegation audit. Each delegate is subject to a formal review at least once a year following the pre-delegation audit. For this EQR, ATC provided a copy of the pre-delegation audit conducted for Express Scripts and copies of the annual audits completed for the non-credentialing delegates.

ATC provided documentation of the oversight conducted for credentialing delegates. Review of the oversight documentation revealed that audits of credentialing delegates is conducted annually and includes review of policies and procedures, committee minutes, ongoing reporting and monitoring, and a review of credentialing and recredentialing files. The oversight documentation confirmed that the file review included all required credentialing and recredentialing elements. However, there was some inconsistency regarding whether recommendations for improvement were given or corrective action was implemented. For example, one delegate (Prisma Palmetto USC) scored 91% and was given recommendations for improvement, yet another (Regional Health Plus Spartanburg) scored 99% and corrective action was implemented. This was discussed with ATC, and it was explained that due to NCQA requirements, certain elements, if not met, require corrective action.

Table 27: Previous Delegation CAP Items includes issues identified during the previous year's EQR and the current status of those findings. As noted, ATC has not sufficiently addressed the finding related to review and discussion of credentialing delegation oversight by the Credentialing Committee.

Table 27: Previous Delegation CAP Items

Standard	2022 EQR Findings	2023 EQR Findings
VI. DELEGATION		
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	No annual oversight documentation was submitted for Envolve People Care Behavioral Health. During onsite discussion, ATC staff stated that an annual evaluation was conducted in 2022, but that delegation would not continue for this delegate in 2023. ATC confirmed they would submit evidence of the 2022 annual evaluation; however, no documentation was received. ATC's documentation reflects that this delegate conducts behavioral health service authorizations and medical necessity denials, along with associated member and provider notice of adverse benefit determination letters, and provider generated complaints. Documentation of annual oversight for the remaining delegates included appropriate audit and file review tools, and documentation of results, recommendations, and any needed corrective actions. Policy CC.CRED.12, Oversight of Delegated Credentialing, states the plan monitors delegate performance in a variety of ways, including by conducting at least annual evaluations to assess performance. • Section III (C) of the policy states summaries of routine oversight meetings and evaluation of interim reporting are presented at the next regularly scheduled Credentialing and/or QIC for review and approval. • Section IV (E) states a summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities and presented to the Credentialing and/or QIC for review and approval. • Section V (E) states reports about any ongoing corrective action plans will be presented to Plan	Policy CC.CRED.12, Oversight of Delegated Credentialing, Section IV (Annual Evaluation, item E states, "Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval." However, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of credentialing delegation oversight. A copy of the 2022 – 2023 SC Delegation Report was included in the folder with the Credentialing Committee minutes, however, it was not mentioned in any of the minutes reviewed.

Standard	2022 EQR Findings	2023 EQR Findings
	Credentialing/QIC at least quarterly. During onsite discussion with staff responsible for delegation oversight activities, it was confirmed that annual oversight evaluations are conducted by corporate staff, and that results of the annual oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). Review and discussion of the reports of non-credentialing delegation were clearly noted in the QIC minutes submitted for review. However, the Credentialing Committee minutes did not reflect review and discussion of credentialing delegation oversight, specifically the items specified in Policy CC.CRED.12 (noted above). During onsite discussion, it was reported that the Credentialing Committee minutes submitted for review were the final minutes. Binders attached to the QIC minutes included copies of Credentialing Committee minutes; however, discrepancies were noted for two sets of minutes when compared to the submitted minutes. After completion of the onsite review, a statement was received from ATC/Centene staff that the originally submitted minutes were not final. Further, the 2021 QI Program Evaluation, page 117, indicates that for all Credentialing delegates, the Credentialing Committee reviewed the results of credentialing delegate audits during the February 8, 2022 meeting. Upon re-examination of the originally submitted Credentialing Committee minutes, as well as the minutes attached to the QIC binders, there was no evidence identified to support this. *Quality Improvement Plan: Ensure annual evaluations are conducted for each delegated entity. To comply with requirements of Policy CC.CRED.12, Oversight of Delegated Credentialing,*	

Standard	2022 EQR Findings	2023 EQR Findings
	implement actions to ensure that either the QIC or Credentialing Committee receives and reviews summaries of routine oversight meetings, evaluations of interim reporting, a summary of the annual delegation review via the Report of Delegation Oversight Activities, and reports about any ongoing corrective action plans.	
ATC Response: The response from Credentialing staff provided during the interview (stating that the Minutes were the final version) was an error, the version of the Minutes submitted to QIC were the finalized version of the Minutes vs the Minutes submitted separately to EQRO. The finalized Credentialing Committee Minutes are submitted to QIC quarterly and are considered the final version. In addition to ensuring that the Delegation Oversight Reports (inclusive of summaries of routine oversight meetings, evaluations of interim reporting, a summary of the annual delegation review and reports about any ongoing corrective action plans) is attached to the Meeting Minutes, a thorough check will be performed to ensure the Minutes submitted are the final version.		

For this EQR, ATC provided the annual evaluation for all entities and no issues were identified.

As noted in *Figure 7: Delegation Findings*, 50% of the standards for Delegation were scored as "Met."

Figure 7: Delegation Findings

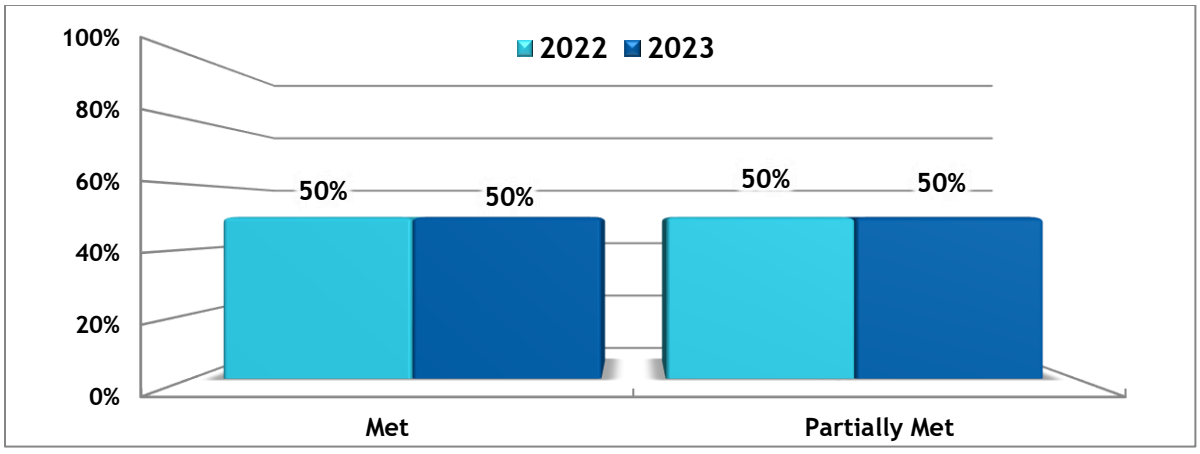


Table 28: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
ATC provided documentation of oversight conducted for non-credentialing and credentialing delegates. For this EQR, ATC provided the annual evaluation for all entities and no issues were identified.	✓		

Table 29: Delegation Weaknesses, Recommendations, and Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy CC.CRED.12, Oversight of Delegated Credentialing, Section IV (Annual Evaluation, item E states, "Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval." During the previous EQR, ATC reported that results of the annual oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). However, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of credentialing delegation oversight. A copy of the 2022 – 2023 SC Delegation Report was included in the folder with the Credentialing Committee minutes, however, it was not mentioned in any of the minutes reviewed.	*Quality Improvement Plan: Ensure Credentialing Committee Minutes clearly and completely document review and discussion of credentialing delegation oversight activities.*	✓		

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					
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 provided documentation of oversight conducted for non-credentialing and credentialing delegates. For this EQR, ATC provided the annual evaluation for all entities and no issues were identified. However, Policy CC.CRED.12, Oversight of Delegated Credentialing, Section IV (Annual Evaluation, item E states, "Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval." During the previous EQR, ATC reported that results of the annual oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for credentialing delegates). However, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of credentialing delegation oversight. A copy of the 2022 - 2023 SC Delegation Report was included in the folder with

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the Credentialing Committee minutes, however, it was not mentioned in any of the minutes reviewed. *Quality Improvement Plan: Ensure Credentialing Committee Minutes clearly and completely document review and discussion of credentialing delegation oversight activities.*

G. Mental Health Parity

The Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008 requires health plans to cover behavioral health/substance use disorder and medical/surgical benefits equally. Constellation Quality Health is required to conduct a Mental Health Parity assessment to determine if ATC met the Mental Health Parity requirements outlined in the *Federal Parity Act*. This assessment is conducted as a two-step process. Step one involves assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits.

Mental Health Parity Non-Quantitative Treatment Limitations (NQTL) Assessment

ATC provided their Medical Program Descriptions, various utilization and network access reports, Member and Provider Handbooks. The corresponding documents for Mental Health/Substance Use Disorder were not provided, therefore Constellation Quality Health was unable to complete the Parity Assessment.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to ATC to complete the mental health parity assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and quantitative treatment limitations (QTLs) that apply to mental health and substance use disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical-surgical (medical/surgical) benefits. ATC did not complete the templates; therefore, Constellation Quality Health was unable to complete the assessment.

Table 30: Mental Health Parity Weaknesses and Quality Improvement Plans

Weaknesses	Recommendations or Quality Improvement Plans	Quality	Timeliness	Access to Care
Insufficient documentation was provided by the health plan to conduct the assessment of Mental Health Parity.	Quality Improvement Plan: In order to determine compliance with the Mental Health Parity and Addiction Equity Act, ATC must complete the Mental Health Parity templates and reports and submit these documents to Constellation Quality Health for review.	✓		

VII. MENTAL HEALTH PARITY

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. MENTAL HEATLH PARITY						
1. The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations.			X			ATC provided their Medical Program Descriptions, various utilization and network access reports, Member and Provider Handbooks. The corresponding documents for Mental Health/Substance Use Disorder were not provided, therefore Constellation Quality Health was unable to complete the Parity Assessment. *Quality Improvement Plan: In order to determine compliance with the Mental Health Parity and Addiction Equity Act, ATC must complete the Non-Quantitative Treatment Limitations templates and reports and submit these documents to Constellation Quality Health for review.*
2. The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.			X			Two templates were provided to ATC to complete the mental health parity assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and quantitative treatment limitations (QTLs) that apply to mental health and substance use disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical-surgical (medical/surgical) benefits. ATC did not complete

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the templates; therefore, Constellation Quality Health was unable to complete the assessment. *Quality Improvement Plan: In order to determine compliance with the Mental Health Parity and Addiction Equity Act, ATC must complete the Mental Health Parity templates and submit these documents to Constellation Quality Health for review.*

Attachments

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

Attachment 1: Initial Notice and Materials Requested for Desk Review

October 16, 2023

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 2023 External Quality Review (EQR) of Absolute Total Care (ATC) is being initiated. An external quality review (EQR) conducted by Constellation Quality Health, formally The Carolinas Center for Medical Excellence, 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 Constellation Quality Health 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, onsite visit and will address all contractually required services as well as follow-up of any areas of weakness identified during the previous review. The Constellation Quality Health EQR team plans to conduct the virtual onsite on December 6th and 7th. In preparation for the desk review, the items on the enclosed desk materials list should be provided to Constellation Quality Health no later than October 30, 2023.

To help with submission of the desk materials, we have set up a secure file transfer site to allow health plans under review to submit desk materials directly to Constellation Quality Health through 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
Project Manager, External Quality Review

cc: SCDHHS

External Quality Review 2023/2024

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. A current Organizational Chart listing staff for all functions, the number of employees in each functional department, and key managers responsible for the functions. For all staff required in the SCDHHS Contract, Section 2, Exhibit 1 and Exhibit 2, indicate whether the staff are in-state, the number of FTEs, and any required designations. For contractually required key positions, provide the portion of time allocated to each Medicaid contract as well as all other lines of business.

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 that support the adequacy of the provider base. Please include the following:
    - Geographic access assessments
    - Network development plans
    - Enrollee demographic studies
    - Population needs assessments
    - Calculation of provider-to-enrollee ratios (PCP and specialist)
    - Analysis of in-network and out-of-network utilization data
    - Provider identified limitations on panel size considered in the network assessment

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 completed Provider Network File Questionnaire.

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

9. 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.

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

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

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

13. 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.

14. 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.

15. 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.

16. 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.

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

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

19. A complete list of all members enrolled in the case management program from December 2022 through September 2023. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

20. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for December 2022 to September 2023. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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

22. A report of findings from the most recent member satisfaction survey (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.

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of December 2022 through September 2023.

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

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

    - Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    - Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

27. 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.

28. 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.

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

30. A copy of the provider handbook or manual.

31. A sample provider contract.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    - A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    - 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.)*
    - A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    - A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    - A copy of the most recent disaster recovery or business continuity plan test results.
    - An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    - A copy of the most recent data security audit, if completed.
    - A copy of the policies or program description that address the information systems security and access management. Please also include policies with respect to email and PHI.
    - A copy of the Information Security Plan & Security Risk Assessment.

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

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

34. 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 Constellation Quality Health's discretion.

35. Results of the most recent annual evaluation and ongoing monitoring activities for all delegated entities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.

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

37. Electronic copies of the following files:
    - Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    - Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    - Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of December 2022 through September 2023. Include any medical information and physician review documentation used in making the denial determination.

- Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of December 2022 through September 2023, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

38. Copies of the following documents needed to complete the Mental Healthy Parity Assessment.
    - Program Descriptions:
        i. Utilization Management
        ii. Mental Health/Substance Use Disorder (MH/SUD)
        iii. Medical/Surgical (MS)
        iv. Quality
    - Reports:
        i. M/S Denial - denial rates, administrative and clinical (IP, OP, ER, RX)
        ii. M/S Appeal – overturn rates (IP, OP, ER, RX)
        iii. M/S Pharmacy Denials - -denial rates, administrative and clinical (IP, OP, ER, RX)
        iv. M/S Pharmacy Appeals - -overturn rates (IP, OP, ER, RX)
        v. MH/SUD Denials- denial rates, administrative and clinical (IP, OP, ER, RX)
        vi. MH/SUD Appeals - overturn rates (IP, OP, ER, RX)
    - Authorization Report
        i. Out of Network Utilization (M/S)
        ii. Out of Network Utilization (MH/SUD)
        iii. Network Access Reports (M/S)
        iv. Network Access reports (MH/SUD)
    - Handbooks/Manuals
        i. Provider Manual
        ii. Member Handbook
        iii. Benefit Documents
    - Parity Tools
        i. Benefit Map (Appendix B)
        ii. NQTL List (Appendix C)
        iii. NQTL Comparison Chart (Appendix D)
        iv. QTL List (Appendix E)
        v. QTL Tool (Excel Spreadsheets)

These materials:

- should be organized and uploaded to the secure Constellation Quality Health's EQR File Transfer site at: https://eqro.thecarolinascenter.org

Attachment 2: Materials Requested for Onsite Review

Absolute Total Care/Wellcare

External Quality Review 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. The following information for the Mental Health Parity Assessment
    a. Authorization Report for:

        Out of Network Utilization (M/S)

        Out of Network Utilization (MH/SUD)

        Network Access Reports (M/S)

        Network Access reports (MH/SUD)

    b. The Completed Parity Tools (attached)

        Benefit Map (Appendix B)

        NQTL List (Appendix C)

        NQTL Comparison Chart (Appendix D)

        QTL List (Appendix E)

        QTL Tool (2 Excel Spreadsheets)
3. Policy addressing the new member packet/new member education.
4. The policy that addresses the process for notifying members of changes in services or benefits.
5. A copy of the Centene Advanced Behavioral Health (CABH) UM Program Description and Program Evaluation.

Attachment 3: EQR Validation Worksheets

EQR Network Adequacy Validation Worksheet

EQR NETWORK ADEQUACY VALIDATION WORKSHEET	
Plan Name:	Absolute Total Care
Reporting Year:	2022
Review Performed:	2023

ACTIVITY 1: ASSESSMENT OF DATA COLLECTION PROCEDURES		
Component / Standard (Total Points)	Score	Comments
1.1 Were all data sources (and years of data) needed to calculate the indicators submitted by the MCO to the EQRO? (1)	MET	Data sources for appropriate timepoints were provided.
1.2 For each data source, were all variables needed to calculate the indicators included? (1)	MET	All variables were reported.
1.3 Are there any patterns in missing data that may affect the calculation of these indicators? (1)	MET	Missing data was addressed.
1.4 Do the MCO's data enable valid, reliable, and timely calculations of the indicators? (1)	MET	Data allowed valid and reliable calculations.
1.5 Did the MCO's data collection instruments and systems allow for consistent and accurate data collection over the time periods studied? (1)	MET	Tools for data collection created systematic processes.
1.6 During the time period included in the reporting cycle, have there been any changes in the MCOs data systems that might affect the accuracy or completeness of network adequacy data used to calculate indicators? (1)	MET	Changes to system were minimal and necessary for appropriate data validity.
1.7 If encounter or utilization data were used to calculate indicators, did providers submit data for all encounters? (1)	MET	Data for information systems were provided.
1.8 If LTSS data were used to calculate indicators, were all relevant LTSS provider services included? (1)	NA	LTSS data not included in NA assessment.
1.9 If access and availability studies were conducted, does the MCO include appropriate calculations and sound methodology? (5)	MET	Studies involved appropriate methodology and calculations.

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
2.1 Are the methods selected by the MCO appropriate for the state? (10)	MET	Methods aligned with State standards.
2.2 Are the methods selected by the MCO appropriate to the state Medicaid and CHIP population(s)? (10)	MET	Methods aligned with populations.

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
2.3 Are the methods selected by the MCO adequate to generate the data needed to calculate the indicators according to the State's expectations? (10)	MET	Methods generated required data for NA assessment.
2.4 Does the MCO use a system for classifying provider types that matches the state's expectations and follows how the state defines a specialist? (1)	MET	Provider network file questionnaire indicated appropriate provider classification.
2.5 If the MCO is sampling a subset of the Medicaid and/or CHIP population, is the sample representative of the population? (1)	MET	Sound sampling methods were applied, wherein necessary.
2.6 If the MCO is sampling a subset of the Medicaid and/or CHIP population, are sample sizes large enough to draw statistically significant conclusions? (1)	MET	Sampling methods were statistically valid.
2.7 Were valid sampling techniques used to protect against bias? Specify the type of sampling used in the "comments" field. (1)	MET	Random sampling was utilized wherein required.
2.8 Does the MCO's approach for measuring time/distance indicators match the state's expectation? (1)	MET	Approach for time/distance aligned with State requirements.
2.9 Does the MCO's approach to deriving provider-to-enrollee ratios or percentage of contracted providers accepting new patients match the state's expectation? (1)	MET	Ratio calculations were conducted according to State requirements.
2.10 Does the MCO's approach for determining the maximum wait time for an appointment match the state's expectation? (1)	MET	Wait time calculations were conducted according to State requirements.
2.11 Are the methods used to calculate the indicators rigorous and objective? (10)	MET	Methods are objective and use of third-party vendors were used wherein applicable.
2.12 Are the methods used to calculate unlikely to be subject to manipulation? (10)	MET	Methodology used mitigated manipulation.

ACTIVITY 3: ASSESSMENT OF MCO NETWORK ADEQUACY RESULTS		
Component / Standard (Total Points)	Score	Comments
3.1 Did the MCO produce valid results? (10)	MET	Results were judged to be valid.
3.2 Did the MCO produce accurate results? (10)	MET	Results were judged to be accurate.
3.3 Did the MCO produce reliable and consistent results? (10)	MET	Results with repeated assessments fell within expectations for reliability and consistency.
3.4 Did the MCO accurately interpret its results? (10)	MET	Findings were interpreted and analyzed by MCO.

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

	Points Possible	Points Earned
Activity 1		
1.1	1	1
1.2	1	1
1.3	1	1
1.4	1	1
1.5	1	1
1.6	1	1
1.7	1	1
1.8	NA	NA
1.9	5	5
Activity 2		
2.1	10	10
2.2	10	10
2.3	10	10
2.4	1	1
2.5	1	1
2.6	1	1
2.7	1	1
2.8	1	1
2.9	1	1
2.10	1	1
2.11	5	5
2.12	5	5
Activity 3		
3.1	10	10
3.2	10	10
3.3	10	10
3.4	10	10
TOTAL	99	99

Points Earned	99
Possible Score	99
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the indicator. *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 indicator in question. *Validation findings below 60% are classified here.*

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	**Absolute Total Care**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2022
Review Performed	2023

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
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:* Press Ganey Child CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022

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. *Documentation:* Press Ganey Child CAHPS Report MY2022
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. *Documentation:* Press Ganey Child CAHPS Report MY2022

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. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2022

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. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child response rate was 10.0% (272 out of 2,723 surveys) which is an increase over last year's rate of 7.8%. However, this response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CAHPS Report MY2022

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	**Absolute Total Care**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2022
Review Performed	2023

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
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:* Press Ganey Adult Population CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

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. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
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. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

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. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For MY2022, the adult response rate was 11.5% (255 out of 2,228) which is an improvement from last year's response rate of 10.3%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to work plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	**Absolute Total Care**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD (CCC)**
Validation Period	2022
Review Performed	2023

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	**MET**	Survey purpose documented in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective is documented in the report. *Documentation:* Press Ganey CCC CAHPS Report MY2022
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:* Press Ganey CCC CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	**MET**	Survey has been tested for validity. *Documentation:* Press Ganey CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey has been tested for reliability. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	Study population was identified. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey CCC CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Procedures to select the sample were appropriate. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* Press Ganey CCC CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* Press Ganey CCC CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	**MET**	Survey data were analyzed. *Documentation:* Press Ganey CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* Press Ganey CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* Press Ganey CCC CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey CCC CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Child with CCC response rate was 9.7% (159 out of 1650), which is an improvement over the previous year's rate of 7.2%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey CCC CAHPS Report MY2022

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey CCC CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey CCC CAHPS Report MY2022

EQR Performance Measure Validation Worksheet

EQR Performance Measure Validation Worksheet	
Plan Name:	Absolute Total Care
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2022
Review Performed:	2023

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2022 Volume 2 Technical Specifications

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

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

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

EQR Performance Improvement Project Validation Worksheet

EQR PIP Validation Worksheet	
Plan Name:	**Absolute Total Care**
Name of PIP:	**Adult Access to Preventive Health Care (AAP)**
Reporting Year:	2021-2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of data.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was appropriate in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services were addressed.
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 relevant 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 was 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 was not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not used.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	The measure was clearly defined in the PIP 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	Indicators measured processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specified data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design described the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data was being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to HEDIS specifications
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel involved in the data collection and their qualifications were mentioned.
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 plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
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 repeat measurements were documented.
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	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	There was improvement in the rate from MY2020 at 77.28% to MY2021 at 78.18%. The benchmark is 81.97%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement was noted as related to interventions in place.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge at this time.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*

EQR Performance Improvement Project Validation Worksheet

EQR PIP Validation Worksheet	
Plan Name:	**Absolute Total Care**
Name of PIP:	**Hospital Readmissions – Clinical**
Reporting Year:	2021-2022
Review Performed:	2023

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of data.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services were addressed.
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 relevant 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 was 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 was not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not used.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	Measured readmissions within 30 days.
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	Indicators measured changes in processes of care and health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specified data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design described the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data was being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to specifications.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel involved in data collection and their qualifications were mentioned.
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 plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
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 repeat measurements were documented.
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	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge was 18.0%, which reduced to 16.2% in 2021, then 15.5% in 2022. The rate met the benchmark.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement related to interventions in place was noted.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to determine at this time.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	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
Project Rating Score	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 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.*