2022 External Quality Review

HEALTHY BLUE

Submitted: June 9, 2022

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2022 External Quality Review (EQR) The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS). This review determines the level of performance demonstrated by Healthy Blue since the 2021 Annual Review.

The goals and objectives of the review include the following:

- Determine if Healthy Blue is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2021 annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and of good quality.

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

Summary and Overall Findings

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

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

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

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

Administration:

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

Healthy Blue has policies and procedures in place to guide business operations. Departments and unit leaders develop, implement, and maintain policies to ensure compliance with applicable state and federal regulations, and accreditation requirements. Policies are stored on a shared drive for convenient employee access, and policy updates are included in a bimonthly newsletter.

The 2022 Organization Chart and Key Personnel List demonstrated sufficient staff are in place to ensure SCDHHS-required health services are provided to members. Onsite discussion addressed the color key specific to the Organizational Chart and updates on key positions.

The Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan outlines the process used to prevent, detect, and respond to violations of ethical standards, contract requirements, and applicable federal regulations. Healthy Blue's Compliance Officer oversees all compliance activities and chairs the Compliance Committee. The Compliance Committee addresses compliance initiatives and risk management concerns for the health plan, is accountable to senior management, and meets each quarter.

The approach to privacy and confidentiality is addressed in Policy MCD-09, Privacy and Confidentiality. This policy outlines the responsibility of each Healthy Blue employee to safeguard member information. All areas are responsible for notifying the Compliance Department of any non-permitted disclosure or if a suspected disclosure has occurred. The Compliance Department reviews all disclosures to determine if the disclosure is a breach that requires further action.

Management Information Systems: Healthy Blue's information systems documentation indicates the organization is capable of satisfying contractual requirements. The MCO has policies and procedures that are based on industry best practices. Additionally, the organization monitors its resources to ensure they are operating properly and identify

system threats. Finally, CCME's review concluded that Healthy Blue has a comprehensive Disaster Recovery Plan that is regularly tested.

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 activities take place under the oversight of the Credentialing Committee, which is chaired by the Chief Medical Officer, and includes external providers with various specialties. The Credentialing Program Plan and related policies detail credentialing and recredentialing processes and requirements. Policy MCD—04, Initial Credentialing, indicates circumstances under which a provider may not appeal credentialing determinations; however, during onsite discussion Healthy Blue staff reported that providers can appeal any denial of credentialing or recredentialing. CCME did not identify any issues in the sample of initial credentialing and recredentialing files for practitioners and organizational providers.

Geographic access standards listed in the Medicaid Access/Availability Standard Policy are compliant with contractual requirements. Healthy Blue conducts Geo Access mapping at least annually. As indicated in the Healthy Blue Network Analysis Drive Distance and Driving Time summaries, dated February 2022, appropriate time and distance parameters are used to measure geographic adequacy of the network. Healthy Blue contracts with all required Status 1 provider types.

The Medicaid Access/Availability Standards Provider policy lists appointment access standards. The policy includes a standard for routine care appointments (scheduled within four weeks of the request) and "health maintenance and preventative care" appointments (scheduled within eight weeks of the request). The Provider Manual also includes the standard for "health maintenance and preventative care." Health plan staff could not differentiate between the two access standards and explained that providers are not monitored for compliance to the "health maintenance and preventive care" standard. The policy does not address appointment access for walk-in patients with non-urgent needs.

The Cultural and Linguistic Program is designed to ensure culturally competent and linguistically appropriate services. Healthy Blue conducts a variety of activities to achieve the program's goals. Provider resources, such as the "Caring for Diverse Populations" toolkit, Cultural Competency Training, and a link to the My Diverse Patients website are available on Healthy Blue's website. The Provider Manual includes a brief chapter on Cultural Competency and a link to the My Diverse Patients website.

Healthy Blue offers a printed version of its Provider Directory as well as the "Find a Doctor" tool on the plan website. Elements that must be included in the online and printed Provider Directory are found in the Provider Directory policy. For the printed directory, the policy does not include office hours and age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1*.

The Telephone Provider Access Study conducted by CCME found that calls were successfully answered 69% of the time, an increase of 10% from last year's rate of 59%. For calls not answered successfully, 41% were unsuccessful because the provider was not at the office or phone number listed.

Healthy Blue conducts an initial provider orientation and education at initial contracting and performs ongoing provider education via on-site and/or virtual sessions. Ongoing provider education provisions also include educational/reference materials, website updates, and special mailings. Healthy Blue holds regional provider training sessions throughout the state at least annually. Comprehensive provider resources are primarily the Provider Manual and the plan website. Providers may contact the health plan as needed for additional information.

Preventive health guidelines and clinical practice guidelines that are relevant to health plan membership are adopted from nationally recognized sources. Adopted guidelines are reviewed at least annually. Information about the guidelines is included in the Provider Manual and the guidelines are posted on Healthy Blue's website. Printed copies are available upon request. Provider compliance with the guidelines is assessed through medical record audits, and through monitoring of utilization data and Health Effectiveness Data and Information Set (HEDIS) gap-in-care data.

Healthy Blue educates network providers about medical record documentation standards and assesses provider compliance through annual Medical Record Compliance Audits for a sample of PCPs. For the 2021 Medical Record Compliance Audit, 96.9% of the providers received passing scores. Results were reported to the Clinical Quality Improvement Committee in April 2022.

Member Services:

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

Member rights and responsibilities are clearly outlined in Policy SC_ QMXX_104, Member Rights and Responsibilities. Members are informed of these rights and responsibilities in the Evidence of Coverage (Member Handbook) and on Healthy Blue's website. Policy SC_COXX_126, Annual Notification to Members, describes Healthy Blue's approach to notifying members of their covered services and benefits. Benefit information is noted on the website and members can contact the Customer Care Center for information and assistance. The previous EQR found that the Evidence of Coverage Change Control log did

not include a date indicating when the changes occurred. CCME provided a Recommendation to add the revision dates to the change control log. Healthy Blue implemented this Recommendation and added the revision dates for the changes made.

Healthy Blue educates members about available Disease Management (DM) programs in the Member Handbook. Information includes that DM staff can help members manage their conditions and that the program is free for members. The handbook lists the different conditions for which DM programs are available, the activities that will be conducted to assist members in managing applicable conditions, and how to request DM services. Information about DM services is also available on the Healthy Blue website.

Member Satisfaction Survey validation for Healthy Blue was conducted based on the CMS Survey Validation Protocol. The health plan conducts a formal annual assessment of member satisfaction that meets all the requirements of the protocol. Healthy Blue contracts with the Center for the Study of Services, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey vendor, to conduct both the child and adult satisfaction surveys. The child survey met the minimum sample size of 411 valid surveys with a total of 452 completed out of 2,673. The response rate was 17.07%, which is a large increase from the previous year's rate of 8.96%. The child with chronic conditions survey sample was below the target of 411, with 362 completed surveys out of 1,650 for a response rate of 22.24%. This is a substantial increase from the previous year's rate of 10.12%. The adult survey response rate was 11.99%, which was an increase from last year's response rate of 10.6%.

Grievances: Policy SC_GAXX 015, Grievance and Appeals for Members, the Member Handbook, and the Healthy Blue website outlines procedures for the receipt and prompt resolution of member grievances. Healthy Blue sends a written acknowledgement of the member's grievance within five calendar days of receipt of the grievance. Grievances are resolved within 90 calendar days with a 14-day extension available if requested. All grievances related to clinical issues are sent to a clinical associate for review and appropriate action. CCME reviewed a sample of grievance files and found that three of the files did not meet Healthy Blue's requirements for sending a written acknowledgement within five calendar days, as outlined in Policy, SC_GAXX-015.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

CCME examined the various aspects of the Quality Improvement section, including the program description, policies, program evaluation, and validation of performance measures and performance improvement projects. Healthy Blue submitted the 2022 Medicaid Quality Management Program Description for this review. This program description is updated annually and submitted to the Clinical Quality Improvement

Committee (CQIC) for approval. The program description describes the Quality Improvement (QI) Program's scope, goals, objectives, structure, and functions for the health plan.

Healthy Blue develops an annual Work Plan. CCME requested and received the 2021 and 2022 Work Plans. The Work Plans included the activities for the year, objectives, frequency, responsible party, completion date, and updates or comments. The tab labeled Contracts and Dashboards was blank on the 2021 Work Plan. It excluded the benchmark/goal and did not record quarterly updates. The Contract and Dashboard tab was also missing from the 2022 Work Plan. Healthy Blue staff mentioned changes were made to the Work Plan based on NCQA updates and the Contract and Dashboard tab was removed in the 2022 Work Plan.

The development, implementation, monitoring, and evaluation of the QI Program is delegated to the CQIC. The CQIC provides oversight for Healthy Blue's efforts to measure, manage, and improve the quality of care and services delivered to members, as well as evaluate the effectiveness of the QI Program. Primary responsibilities are included in the committee charter. CQIC membership includes both health plan staff and external contracting providers. Meetings are co-chaired by the Healthy Blue Medical Director and the assistant Vice President, Medicaid. Voting members include seven actively participating providers who specialize in family medicine, obstetrics (OB)/gynecology (GYN), pediatrics, emergency medicine, and psychiatry.

Healthy Blue evaluates the overall effectiveness of the QI Program and reports this assessment to the CQIC. The health plan submitted the 2020 Medicaid Quality Management Program Evaluation for review. The program evaluation included the results of all completed activities conducted in 2020. Results of the evaluation are used to develop recommendations for improvement and priorities for the upcoming year. CCME did not identify any issues with the program evaluation.

Performance Measure Validation: CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Healthy Blue was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*. All relevant HEDIS performance measures for the current measure year (2020), as well as the previous measure year (2019), and the change from 2019 to 2020 are reported in the Quality Improvement section of this report.

The comparison from the previous to the current year revealed a greater than 10% increase in six measures and one measure, Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) cholesterol testing for 12 to 17 year olds had a

substantial decline of more than 10%. *Table 1* highlights the HEDIS measures with substantial changes in rate from last year to the current year.

Table 1: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	58.53%	69%	10.47%
Follow-Up After Hospitalization for Mental Illness (fuh) -			
6-17 years - 7-Day Follow-Up	40.09%	52.09%	12.00%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	29.02%	40.89%	11.87%
Total	29.02%	40.89%	11.87%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	24.18%	35.41%	11.23%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	24.13%	35.10%	10.97%
Substantial Decrease in Rate (>10% decrease)			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Cholesterol Testing - 12-17 Years	32.91%	22.43%	-10.48%

Performance Improvement Project Validation: CCME validated the performance improvement projects (PIPs) following the CMS protocol titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its documentation to provide an assessment of the project's overall study design and methodology. For this EQR, Healthy Blue submitted two PIPs for validation: The Comprehensive Diabetes Care PIP and a new PIP, CAHPS – Child with Chronic Conditions Customer Service PIP. The PIPs met the validation requirements and received scores within the "High Confidence Range." The tables that follow provide an overview of the previous validation scores with the current scores, and a summary of interventions for each project.

Table 2: Comprehensive Diabetes Care PIP

Comprehensive Diabetes Care
The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. Both indicators showed baseline rates. The HbA1C >9% rate was 51.09% with a goal of 58.75%. The Retinal eye exam indicator rate was 35.35% with a goal of 37.35%.

Comprehensive Diabetes Care	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	93/93= 100% High Confidence in Reported Results
Interventions	
• Targeted text messages outreach calls to members who have been diagnosed as being Diabetic to ensure that the member has their HbA1c screenings and Diabetic Retinal Eye Exams. • Member that become compliant on the following services- A1c test, eye exam and completion of diabetes survey will be able to choose gift cards from various platforms. In-addition to gift cards; members can receive fresh fruits and veggies. • Practice Consultants visit (webinars) providers, review their current Gap in Care, provide a PowerPoint presentation with HEDIS information and answer any questions that the provider may have. • Case Managers offer members assist with PCP appointments, pharmacy and any SDOH needs.	

Table 3: CAHPS – Child with Chronic Conditions Customer Service PIP

CAHPS – Child with Chronic Conditions Customer Service	
The aim for this PIP is to improve the Child CAHPS measure: Customer Service Provided Information/Help. This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass.	
Previous Validation Score	**Current Validation Score**
Not Submitted	88/93= 95% High Confidence in Reported Results
Interventions	
• Oversampling • Provide a Spanish Survey	

CCME's EQR noted the current interventions for the CAHPS PIP seemed focused on improving response rates and reaching a larger audience, but not necessarily on improving customer service scripts or resources.

Utilization Management:

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

Healthy Blue provided the 2022 Utilization Management Program Description, titled Utilization Management (UM) Program Description Template 2022, for review. The UM Program Description and several policies and documents guide staff in conducting UM functions. The UM Program Description was last reviewed and approved in April 2022.

Healthy Blue evaluates the UM Program annually. Results and recommendations are presented to the Quality Improvement Committees as applicable. The UM Program Evaluation covering measurement year 2021 was provided as evidence of this evaluation.

Healthy Blue's screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the Medical Policy and Technology Assessment Committee (MPTAC) and the CQIC. Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, and Policy and Procedure Clinical Criteria for Utilization Management Decisions – Core Process, discuss the process for applying criteria and dissemination of the criteria to members and providers as requested. UM staff receive updates about interpretation and application of the criteria guidelines. Requests for medical services that do not meet the criteria for medical necessity or require further medical review are routed to a Peer Clinical Reviewer. Only licensed physicians are able to deny a medical service or treatment.

The UM Program Description along with Policy SC_UMXX_120, Nurse Inter-Rater, and Policy SC UMXX 078, Physician Inter-Rater Reliability Assessment, describe the process Healthy Blue uses to evaluate the quality and consistency of clinical decisions among reviewers. Nurse reviewers, medical directors and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually. The benchmark or goal is 90%. Any score below 90% requires documented re-education, re-testing, and auditing. Results of the 2021 Inter-Rater Reliability (IRR) were reported in the UM Program Evaluation. Barriers and opportunities for improvements were also identified.

The Pharmacy Program Description explains that IngenioRx is the pharmacy benefit manager responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities. Healthy Blue's website contains information about covered prescriptions, including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. However, it was not clear when the changes were posted to the website. The Pharmacy Program Description, page 10, indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the *SCDHHS Contract* requires the change be published on the website at least 30 days prior to implementation.

Appeals: Healthy Blue's Policy, SC_GAXX_051, Member Appeal Process-SC, describes how appeals are submitted and processed. Appeal information is provided in the Member Handbook, Provider Manual, and on the website. The website also includes forms for members and providers to file an appeal.

CCME's review of appeal files revealed that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process.

Case Management (CM) processes and activities are described in the Complex Case Management 2021-2022 Program Description, the 2022 Population Health Program Description, and in policies and procedures. Methods for member identification are clearly described, and include both internal and external referrals, predictive modeling, data mining, and health risk assessments. Specific diagnosis and/or procedure codes may trigger a referral for CM services. All newly enrolled members receive a printed Health Risk Screening form to complete and return to the plan. Plan staff reported good response rates to the mailed screening forms.

Members are stratified into five levels using predictive modeling and other methods to rank members from lowest risk to highest risk, so that appropriate CM activities and interventions are included in the plan of care and management of the member.

CCME's review of a sample of physical health and behavioral health CM files confirmed that Healthy Blue conducted appropriate activities to manage members in the CM Program. No issues were identified.

Health Blue conducts an annual CM Program evaluation to assess the efficiency and effectiveness of the program and to monitor year-over-year performance and outcomes. Member satisfaction with the program is evaluated through a telephonic survey process. The survey results are reviewed quarterly to identify trends and opportunities for improvement. These evaluations inform process improvement activities to address any identified inefficiencies or problem areas.

Delegation:

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

Delegation agreements are in place between Healthy Blue/Amerigroup and entities to which health plan activities are delegated.

The Delegate/Vendor Oversight and Management Program policy and procedure document describes processes for delegation of health plan activities and oversight of delegated entities. Potential delegates are subjected to pre-delegation assessment to determine capabilities for conducting functions in compliance with all requirements.

Established delegates are subjected to annual oversight and ongoing monitoring. The health plan conducts pre-delegation and annual assessments using standardized audit tools that are specific to functional areas.

Documentation was submitted for all delegated entities showing annual and/or pre-delegation assessment conducted within the last year. The documentation includes recommendations made and shows that corrective actions were implemented when appropriate. For credentialing delegates, the file review worksheets do not reflect that the delegates are assessed for compliance with the initial credentialing processing timeframe stated in the *SCDHHS Contract, Section 2.8.2.4.2*, or for ensuring applicable providers have admitting privileges.

State Mandated Services:

42 CFR § Part 441, Subpart B

Healthy Blue's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is designed to comply with the recommendations of the American Academy of Pediatrics (AAP) for the provision of health screenings and services for children through the month of their 21st birthday. Provider compliance with the recommendations for EPSDT services and immunizations is monitored through the formal Medical Record Compliance Audit process and by monitoring HEDIS performance gap-in-care data.

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

The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10-day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were four standards scored as "Partially Met" and two standards scored as "Not Met." Following the 2021 EQR, Healthy Blue submitted a Quality Improvement Plan to address the deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on August 2, 2021. The following is a high-level summary of those deficiencies:

- Several initial credentialing and recredentialing files did not include Clinical Laboratory Improvement Amendments (CLIA) certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary

practice location, and CLIA certificates for other locations are maintained in the Claims area.

- The Telephonic Provider Access Study CCME conducted did not show improvement from the previous study's results.
- CCME's review of appeal files revealed that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process.
- CCME's review of Healthy Blue's documentation of delegation oversight revealed issues related to lack of documentation on the MCO Credentialing File Review Workbook in connection with querying the National Plan and Provider Enumeration System, querying the Social Security Death Master File, and collection of nurse practitioner collaborative agreements.
- Deficiencies identified during the 2020 EQR regarding oversight of credentialing delegates were not corrected.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plan that addressed the timeliness for sending the appeal case file to the member outlined in Healthy Blue's policy was not implemented.

Conclusions

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

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

Category	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	8	7	87.5%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	8	8	100%

Category	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	14	13	92.8%
• Provider Selection *(§ 438.214, § 457.1233)*	39	39	100%
• Confidentiality *(§ 438.224)*	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	20	18	90%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	2	1	50%
• Practice Guidelines *(§ 438.236, § 457.1233)*	11	11	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	14	14	100%

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

As noted in the table above:

- For Availability of Services and Assurances of Adequate Capacity and Services, one of eight standards was scored as "Partially Met" due to incorrect and missing information from the Medicaid Access/Availability Standard policy.
- For Coverage and Authorization of Services, one of 14 standards was scored as "Partially Met" related to information published on the website regarding negative PDL changes.
- For Grievance and Appeal Systems, two standards were scored as "Partially Met" due to untimeliness for sending a written acknowledgement for the grievances, providing the member appeal case file, and the physicians who made some of the appeal decisions were not of the same or similar specialty as the ordering physician.
- For Sub-contractual Relationships and Delegation, one of two standards was scored as "Partially Met" due to omissions in the delegation oversight documentation.

Table 5, Scoring Overview, provides an overview of the scoring of the current EQR as compared to the findings of the 2021 EQR. For 2022, 208 of 214 standards received a score of "Met." There were five standards scored as "Partially Met" and one standard related to an uncorrected deficiency that received a "Not Met" score.

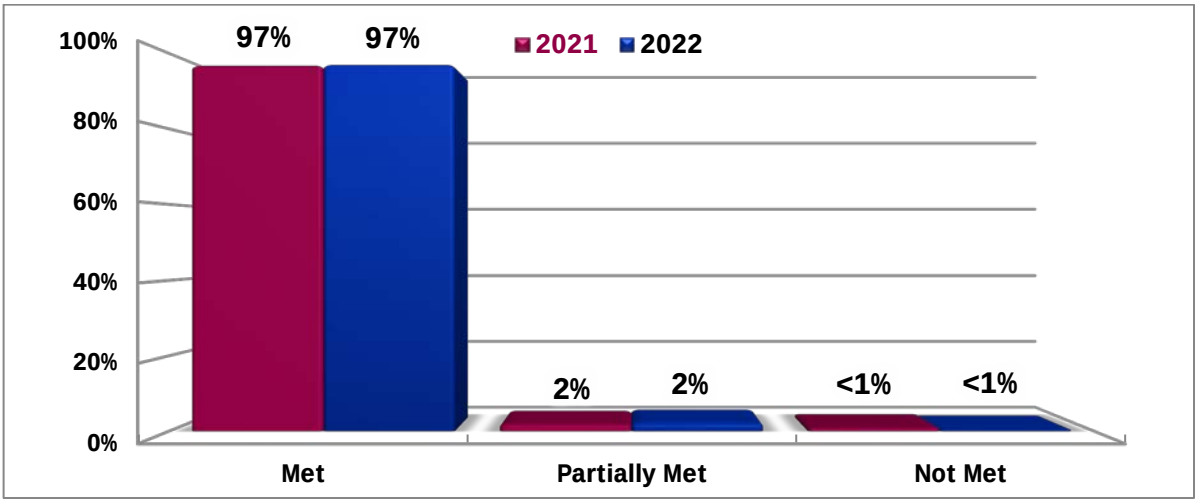
Table 5: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	40	0	0	0	0	40	100%
2022	40	0	0	0	0	40	100%
Provider Services							
2021	72	2	1	0	0	75	96%
2022	75	1	0	0	0	76	99%
Member Services							
2021	33	0	0	0	0	33	100%
2022	32	1	0	0	0	33	97%
Quality Improvement							
2021	14	0	0	0	0	14	100%
2022	14	0	0	0	0	14	100%
Utilization							
2021	44	1	0	0	0	45	98%
2022	43	2	0	0	0	45	96%
Delegation							
2021	1	1	0	0	0	2	50%
2022	1	1	0	0	0	2	50%
State Mandated Services							
2021	3	0	1	0	0	4	75%
2022	3	0	1	0	0	4	75%
Totals							
2021	**207**	**4**	**2**	**0**	**0**	**213**	**97%**
2022	**208**	**5**	**1**	**0**	**0**	**214**	**97.20%**

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

The 2022 Annual EQR shows that Healthy Blue achieved "Met" scores for 97% of the standards reviewed. As the following chart indicates, 2% of the standards were scored as "Partially Met," and 0.47% were scored as "Not Met." The chart that follows provides a comparison of the current review results to the 2021 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 6: Evaluation of Quality

Strengths Related to Quality
• Healthy Blue has policies and procedures in-place that are reviewed on a regular basis. • The Disaster Recovery Plan is tested regularly. The most recent DR test involved recovering and testing failover to a secondary data center. The test was completed successfully with minimal issues. The issues that were discovered were documented and addressed during the exercise. • 100% of the initial credentialing and recredentialing files were compliant with all credentialing requirements for practitioners and organizational providers. • Ongoing provider education is conducted via on-site and/or virtual sessions and regional provider training sessions are held throughout the state at least annually. • For the 2021 Medical Record Compliance Audit, 96.9% of the providers received passing scores. Only two providers required reaudit. • The response rates for the member satisfaction surveys showed an increase from the previous year's response rate. • The following HEDIS MY 2020 measure rates were strengths for Healthy Blue since their rates had a greater than 10% improvement: o Pharmacotherapy Management of COPD Exacerbation (pce), Systemic Corticosteroid improved 10.47% from last year. o Follow-Up After Hospitalization for Mental Illness (FUH), 6-17 years - 7 Day Follow-Up improved 12%. o Pharmacotherapy for Opioid Use Disorder (pod), 16-64 years and Total improved almost 12%.

Strengths Related to Quality
• All performance improvement projects scored within the "High Confidence Range" for the reported results. • UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination. • Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-Rater Reliability testing. • Case Management program descriptions and policies thoroughly document processes and activities to identify members as potential candidates for Case Management services, as well as member assessment, care plan development, and ongoing monitoring activities. • Member satisfaction with the Complex Case Management program is evaluated through a telephonic survey process, and survey results are reviewed quarterly to identify trends and opportunities for improvement. • Potential delegates are subjected to pre-delegation assessment to determine their ability to conduct functions in compliance with all requirements. Established delegates are subjected to annual oversight and ongoing monitoring. • Pre-delegation assessments and annual assessments are conducted using standardized audit tools that are specific to functional areas. • Healthy Blue ensures the provision of EPSDT services and immunizations recommended in the AAP Periodicity Schedules and monitors provider compliance with the recommended guidelines and services. • Primary care providers are routinely notified of members who may not have received EPSDT services according to schedule.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Healthy Blue staff reported during onsite discussion that providers can appeal any determination to deny credentialing or recredentialing. However, Policy MCD—04, Initial Credentialing, item 11, indicates circumstances under which a provider may not appeal credentialing/recredentialing determinations.	• Recommendation: Update Policy MCD-04 to clarify when/if providers may appeal decisions to deny credentialing and recredentialing determinations.
• Policy MCD-21, Provider Directory, lists elements that must be included in the printed Provider Directory; however, it does not include office hours and age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1*.	• Recommendation: Revise Policy MCD-21, Provider Directory, to include office hours and age groups as required elements of the print version of the Provider Directory.
• It was noted the current interventions for the CAHPS PIP seemed focused on improving response rates and reaching a larger audience, but not necessarily improving customer service scripts or resources.	• Recommendation: Include interventions in the CAHPS - Child with Chronic Conditions Customer Service PIP that directly address improving customer service.
• Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process.	• Quality Improvement Plan: Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy, SCDHHS Contract and federal regulations. Implement interventions to address the barriers.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• For credentialing delegates, the file review worksheets do not reflect that the delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges.	• Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for compliance with initial credentialing timeframe requirements and for ensuring applicable providers have admitting privileges or an admitting arrangement. These elements should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.
• The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10 day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process.	• Quality Improvement Plan: Implement quality improvement plans from the External Quality Review to address all identified deficiencies.

Table 7: Evaluation of Timeliness

Strengths Related to Timeliness
• Healthy Blue processes provider claims at a rate that exceeds the State's requirements. • Grievances files reviewed demonstrated Healthy Blue resolves grievances within the required timeframe. • Utilization management decisions were timely, and members were notified of these decisions appropriately.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
• The Preferred Drug List change document found on the website did not include the date the change was published on the website. Also, the Pharmacy Program Description, page 10 indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the contract requires the change be published on the website at least 30 days prior to implementation.	• Quality Improvement Plan: Update the PDL change document posted on the website and include the date the change document was posted. Also, update the Pharmacy Program Description to indicate that changes are published on the website at least 30 days prior to implementation as required by the *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3.*
• Three of the grievance files did not meet Healthy Blue's policy (SC_GAXX-015) for sending a written acknowledgement within five calendar days.	• Quality Improvement Plan: Conduct an internal audit of files to ascertain compliance with Healthy Blue's grievance policy. Address any deficiencies with staff to determine interventions needed to address performance.

Table 8: Evaluation of Access to Care

Strengths Related to Access to Care
• The 2022 Organization Chart and Key Personnel List demonstrated sufficient staff are in place to ensure health services required by SCDHHS are provided to members. • The Network Growth Report for MY 2021, dated March 10, 2022, indicates an increase of approximately 900 network providers from January to December 2021. • For the Telephone Provider Access Study conducted by CCME, calls were answered successfully 69% of the time.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• Policy MCD-11, Medicaid Access/Availability Standard, includes the "Physician Office Accessibility Standards" table on page 4 that includes an appointment access standard for routine care (within four weeks of request) and also includes an appointment access standard for "Health Maintenance and Preventative Care" (within 8 weeks). The Provider Manual, page 115 also lists the additional standard for Health Maintenance and Preventative Care. Healthy Blue staff were unable to describe the difference between routine care and health maintenance/ preventive care. Staff also confirmed that this standard is not monitored. Also, the policy does not address the requirement from the *SCDHHS Contract, Section 6.2.2.3.5*, that "Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures."	• Quality Improvement Plan: Revise Policy MCD-11 to remove the appointment standard for Health Maintenance and Preventative Care. Include information that walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

METHODOLOGY

The process CCME used for the EQR activities was based on protocols CMS developed for Medicaid MCOs/Prepaid Inpatient Health Plans (PIHP) and focuses on the three federally mandated EQR activities of compliance determination, validation of performance measures, and validation of performance improvement projects.

On March 14, 2022, CCME sent notification to Healthy Blue that it was initiating the Annual EQR (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Healthy Blue to ask questions about the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from Healthy Blue on March 28, 2022 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on May 11th and May 12th. The onsite visit focused on areas not covered in the desk review or needing clarification. See *Attachment 2* for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with Healthy Blue's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

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

A. Administration

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

Healthy Blue has policies and procedures in place to guide business operations. Departments and unit leaders develop, implement, and maintain policies to ensure compliance with relevant state and federal regulations, and accreditation requirements.

Policies are stored on a shared drive for convenient employee access, and policy updates are included in a bimonthly newsletter.

The 2022 Organization Chart and Key Personnel List demonstrated sufficient staff are in place to ensure health services required by SCDHHS are provided to members. Onsite discussion addressed the color key specific to the Organizational Chart and updates on key positions.

The Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan (Compliance Plan) outlines the process to prevent, detect, and respond to violations of ethical standards, contract requirements, and applicable federal regulations. The Compliance Plan is regularly reviewed and updated as needed. Written policies, procedures, and standards of conduct are made available to employees at the time of employment and annually, thereafter.

Healthy Blue's Compliance Officer oversees all compliance activities and chairs the Compliance Committee. The Compliance Committee addresses compliance initiatives and risk management concerns for the health plan, is accountable to senior management, and meets each quarter.

Healthy Blue provides compliance education and training to employees regarding legal and ethical obligations based on applicable laws, regulations, and policies. Onsite discussion indicated training is required during onboarding and annually via the Learning Management System. The Compliance and Human Resources Departments track training scores. The health plan monitors and conducts periodic audits of adherence to written policies, procedures, and Code of Conduct to develop metrics for evaluating compliance with regulatory standards. This allows Healthy Blue to identify areas that require Quality Improvement Plans.

The approach to privacy and confidentiality is addressed in Policy MCD-09, Privacy and Confidentiality. This policy outlines the responsibility of each Healthy Blue employee to safeguard member information. All staff are responsible for notifying the Compliance Department of any suspected or actual non-permitted disclosure. The Compliance Department reviews all reports of disclosures to determine if the disclosure is a breach that requires notification.

Information Management Systems Assessment

Healthy Blue's Information Systems documentation indicates the organization is capable of satisfying requirements of the *SCDHHS Contract*. Healthy Blue's claims benchmark requires the organization to pay 98% of claims within 30 days, and 99% of claims within 90 days. This benchmark exceeds the State's requirement and is reflected in the organization's measured average claim payment times. Systems are capable of accepting

and generating Health Information Portability and Accountability Act (HIPAA)-compliant electronic transactions. It was specifically noted in the health plan's documentation that the organization uses industry standard formats for its electronic and paper claims.

Healthy Blue's business partner updates 834 files daily and uses the unique SCDHHS assigned number from the enrollment files to identify enrollees. The organization noted that its systems use state-assigned member numbers, and members are referenceable across multiple systems with that state-assigned number. Finally, duplicate records are checked during initial entry and again during adjudication.

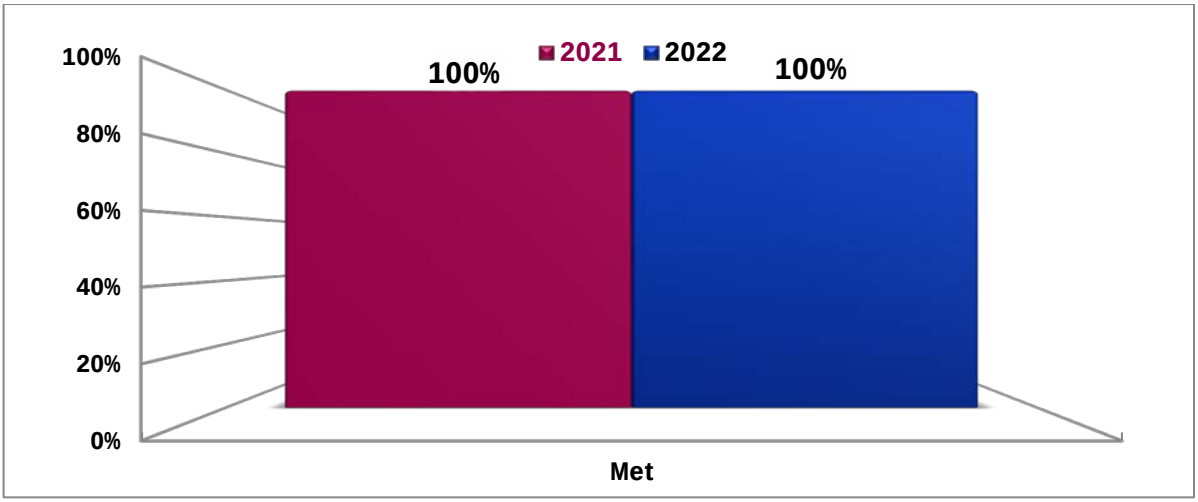
Healthy Blue and its business partners use National Committee for Quality Assurance (NCQA)-certified software to generate Medicaid HEDIS and HEDIS-like reports. Reporting data is updated monthly and the MCO reviews the data to ensure reasonableness.

Healthy Blue requires Federal Information Processing Standard (FIPS) 140-2 approved encryption methods for data in transit, storage, and at rest. Additionally, the MCO requires full disk encryption for laptops and desktops as well as any mobile devices that store confidential data. Healthy Blue has implemented policies and procedures to secure its systems, networks, and physical premises. Access to the health plan's systems is granted on the principal of least privilege. Additionally, the health plan requires multifactor authentication for systems to be accessed remotely.

Healthy Blue's Disaster Recovery (DR) Plan is comprehensive and is tested on a scheduled basis. The most recent DR test involved recovering and testing failover to a secondary data center. The test was completed successfully with minimal issues. Discovered issues were documented and addressed during the exercise.

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

Figure 2: Administration Findings



Strengths

- Healthy Blue regularly reviews policies and procedures.
- The 2022 Organization Chart and Key Personnel List demonstrated sufficient staff are in place to ensure health services required by SCDHHS are provided to members.
- Healthy Blue processes provider claims at a rate that exceeds the State's requirements.
- The DR Plan is tested regularly. The most recent DR test involved recovering and testing failover to a secondary data center. The test was completed successfully with minimal issues. Discovered issues were documented and addressed during the exercise.

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 files, processes for evaluating adequacy of the provider network and practitioner accessibility, provider education processes, provider compliance with preventive health and clinical practice guidelines, continuity of care, and practitioner medical record requirements.

Provider Credentialing and Selection

§ 438.214, § 457.1233

The overall credentialing process is addressed in the Healthy Blue Credentialing Program Plan. Related policies provide detailed information about credentialing and recredentialing processes and requirements. Onsite discussion confirmed providers can appeal any denial of credentialing or recredentialing. However, Policy MCD—04, Initial Credentialing, item 11, indicates there are circumstances under which a provider may not appeal credentialing determinations.

The BlueChoice HealthPlan Chief Medical Officer chairs the Credentialing Committee, which meets monthly. A quorum is established with the presence of three external committee members. Committee membership includes an array of external providers with various specialties, including internal medicine, pediatrics, pulmonology, obstetrics and gynecology, a nurse practitioner, and a chiropractor. Internal practitioners include a pediatrician and an ophthalmologist. Onsite discussion revealed Healthy Blue replaced one external committee member due to attendance that did not meet the requirements established in the Provider Credentialing/Recredentialing Charter.

No issues were identified in the sample of initial credentialing and recredentialing practitioner files reviewed. Likewise, initial credentialing and recredentialing files for organizational providers did not reveal any issues. The current EQR confirmed Healthy Blue addressed and corrected the findings from the previous EQR. See *Table 9* for details of the previous review finding and the health plan's response.

Table 9: Previous Provider Credentialing and Selection QIP Items

Standard	EQR Comments
Credentialing and Recredentialing	
3.1 Verification of information on the applicant, including: 3.1.15 CLIA Certificate (or certificate of waiver) for providers billing laboratory procedures;	Three of the 14 initial credentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area. *Quality Improvement Plan: Revise credentialing processes to include evidence of CLIA certificates for all applicable practice locations in the credentialing files.*
Healthy Blue's Response: The credentialing application has been updated to include the capture of CLIA certification numbers for all of a provider's practice locations (No. 9 on attached application). A policy has been implemented (draft attached) that describes the process to be utilized to assure staff collect the CLIA certificate numbers and verify the CLIA certificates for each provider practice location. Provider educational materials will include information on inclusion of CLIA certificate numbers for all practice locations on the	

Standard	EQR Comments
application. Monthly provider newsletter will inform providers of the requirement for them to enter the CLIA certificate number for all practice locations on the application. The application check list used by the credentialing specialists includes the validation of CLIA certificates for all practice locations and to include those verifications in each application packet for the providers to which this applies.	
4.2 Verification of information on the applicant, including: 4.2.14 CLIA Certificate for providers billing laboratory procedures;	Three of the 18 recredentialing files did not include CLIA certificates for all practice locations. Onsite discussion confirmed credentialing staff verify the CLIA only for the primary practice location, and CLIA certificates for other locations are maintained in the Claims area. *Quality Improvement Plan: Revise recredentialing processes to include evidence of CLIA certificates for all applicable practice locations in the recredentialing files.*
Healthy Blue's Response: The re-credentialing application has been updated to include the capture of CLIA certification numbers for all of a provider's practice locations. A policy has been implemented (draft attached) that describes the process to be utilized to assure staff collect the CLIA certificate numbers and verify the CLIA certificates for each provider practice location. Provider educational materials will include information on inclusion of CLIA certificate numbers for all provider practice locations on the application. Monthly provider newsletter will inform providers of the requirement for them to enter the CLIA certificate number for all practice locations on the application. The application check list used by the credentialing specialists includes the validation of CLIA certificates for all practice locations and to include those verifications in each application packet for the providers to which this applies.	

Policy MCD-07, Professional Practitioner – Restriction, Suspension or Termination Processes, provides information about processes for restricting, suspending, or terminating a provider's network participation when issues of quality of care are identified. Network participation may also be restricted, suspended, or terminated when there are federal sanctions or if the provider fails to meet credentialing standards. Policy MCD-07 addresses provider notification, reporting to state agencies, the National Practitioner Data Bank (NPDB), state licensing boards, etc.

Availability of Services

§ 438.206, § 438.207, and § 457.1230

Geographic access standards for primary care providers (PCPs), specialists, and hospitals are defined in Policy MCD-11, Medicaid Access/Availability Standard. Standards listed in the policy are compliant with contractual requirements. Healthy Blue conducts Geo Access mapping at least annually. The Healthy Blue Network Analysis Drive Distance – Summary and the Driving Time Part 1, both dated February 2022, reflect use of appropriate time and distance parameters to measure geographic adequacy of the network. Healthy Blue contracts with all required Status 1 provider types. Healthy Blue also monitors member satisfaction survey results and member grievances to assess member access to providers.

Provider appointment access standards are found in Policy MCD-11, Medicaid Access/Availability Standards. The "Physician Office Accessibility Standards" table on page four of the policy states "routine care appointments should be scheduled within four weeks of request." However, the last line of the table states, "Health Maintenance and Preventative Care –To meet criteria, appointments should be scheduled within 8 weeks." Page 115 of the Provider Manual also lists the additional standard for Health Maintenance and Preventative Care. Furthermore, the policy does not address the requirement from the *SCDHHS Contract, Section 6.2.2.3.5*, that "Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures."

The Cultural and Linguistic Program is designed to ensure culturally competent and linguistically appropriate services. Healthy Blue relies on several factors to assess the provider network. Key factors include member population and member language preferences. Additional activities undertaken to achieve the program's goals include the following:

- Contracting with practitioners who are committed to serving a diverse population.
- Providing a comprehensive provider training program to reduce disparities.
- Assessing the language capabilities of the provider network against the member population and language preferences.
- Conducting an annual assessment to determine the ability of the network to meet member language needs and provide culturally competent care.
- Employing multilingual associates, when possible.

Provider resources, such as the "Caring for Diverse Populations" toolkit, Cultural Competency Training, and a link to the My Diverse Patients website are available on Healthy Blue's website. The Provider Manual includes a brief chapter on Cultural Competency and a link to the My Diverse Patients website.

Healthy Blue offers a printed version of its Provider Directory as well as the "Find a Doctor" tool on the plan website. Elements that must be included in the online and printed Provider Directory are found in Policy MCD-21, Provider Directory. For the printed directory, the policy does not include office hours and age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1*.

Provider Access and Availability Study

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

The Healthy Blue Provider File contained a population of 2,313 PCPs. To conduct the Telephone Provider Access Study, CCME selected a random sample of 170 PCPs. CCME

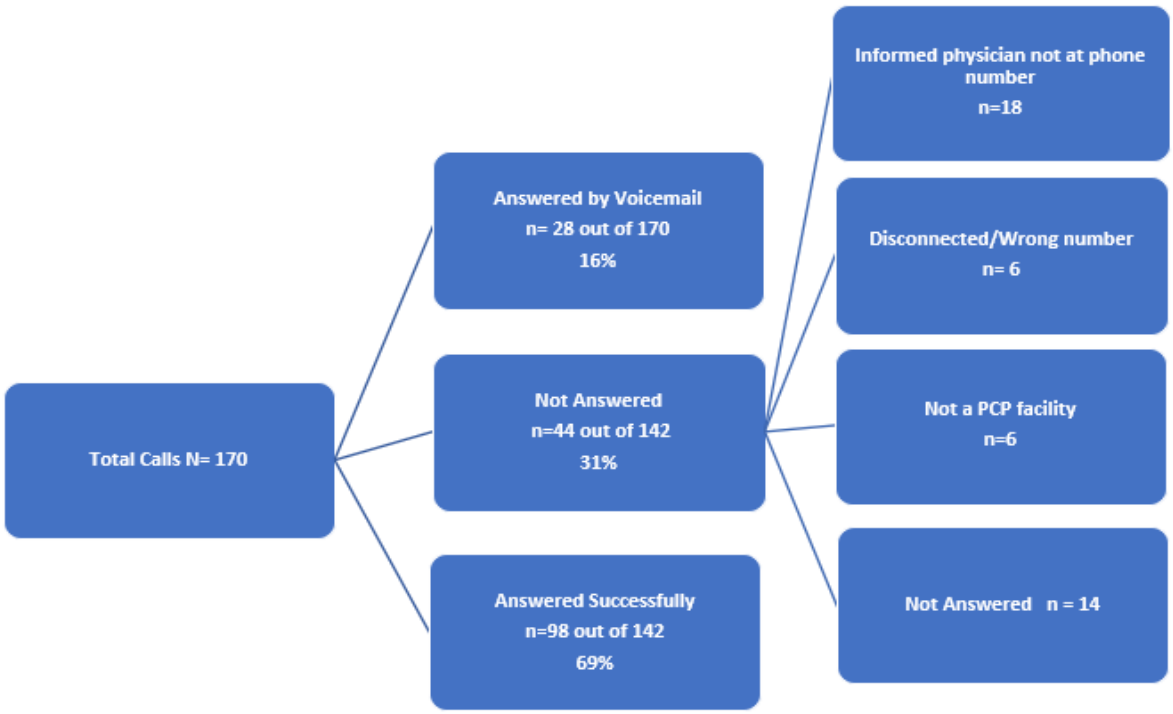
chose PCPs based on the following credentials: MD, DO, NP, ANP, CFNP, and FNP. Selected specialties included family practice, general practice, internal medicine, nurse practitioner, and pediatrics. CCME only selected providers located in SC and documented as accepting new patients for the sample. CCME attempted to contact the providers to ask a series of questions regarding access that members have to the providers.

Table 10: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2021 Review	176	59%	.052
2022 Review	170	69%	

For the Telephonic Provider Access Study, calls were answered successfully 69% of the time. When compared to last year's results of 59%, the increase in successful answer rate was not statistically significant (p = .052). For those not answered successfully (n=44 calls), 18 (41%) were unsuccessful because the provider was not at the office or phone number listed. *Figure 3: Telephonic Provider Access Study Results* provides an overview of the findings of the Telephonic Provider Access Study.

Figure 3: Telephonic Provider Access Study Results



Of the 98 providers contacted, 91 (93%) indicated they accept Healthy Blue, and seven (7%) indicated they did not accept Healthy Blue. Of the 91 accepting Healthy Blue, 26 (29%) were not accepting new patients and 65 (71%) were accepting new patients. Regarding a screening process for new patients, 28 (43%) reported there is a screening process and 37 (57%) reported there is no screening process for new patients.

Of the 28 that do require screening, eight (29%) require an application, 17 (61%) require a medical record review, one (4%) required both an application and a medical record review, and two (7%) required vaccination records.

Table 11: Previous Practitioner Accessibility QIP Items reflects the findings from the 2021 Telephonic Provider Access Study and Healthy Blue's response to the Quality Improvement Plan.

Table 11: Previous Practitioner Accessibility QIP Items

Standard	EQR Comments
Adequacy of the Provider Network	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	The Healthy Blue Provider File contained a population of 2,430 PCPs. From that, a random sample of 176 PCPs was selected for the provider access study. PCPs were chosen based on the following criteria: MD, DO, NP, ANP, CFNP, and FNP. The specialties selected were Family Practice, General Practice, Internal Medicine, Nurse Practitioner, and Pediatrics. Only Providers located in SC and documented as accepting new patients were selected for the sample. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. In reference to the results of the Telephone Provider Access Study, conducted by CCME, calls were successfully 59% of the time. When compared to last year's results of 77%, the decrease in successful answer rate was statistically significant (p = .0002). For those not answered successfully (n=67 calls), 33 (49.3%) were unsuccessful because the provider was not at that office or phone number listed. *Quality Improvement Plan: Examine current methods to update provider information; ensure all provider files are up to date; offer providers several methods to update contact information and primary location. Check the unsuccessful calls file from CCME.*
Healthy Blue's Response: We have reviewed the unsuccessful call file provided by CCME. Using the file, we determined several updates to the provider directory were needed. We also discovered, however, that some Hospitalists not listed in our provider directory – but listed in the provider file we provide to auditors - had been contacted by the auditors.	

Standard	EQR Comments
While the provider primary specialties for the Hospitalists are that of PCPs, the providers were in fact suppressed from our directory since they are practicing as Hospitalists and not PCPs. We will make every effort to make this distinction in future files pulled from our system to send to auditors. Here are some current and future enhancements to verify and update Provider Data: •Secret Shopper Outreach and Provider Education Outreach – calls placed to providers as a potential new patient asking questions related to office address, accepting new patients and network participation. Then, verification calls are placed as caller from the payor. •Providers may validate their information via email, telephone, or our online portal: MDCheckup. All locations are prompted to verify their data at least once per quarter via MDCheckup messages, email and/or telephone outreach by BlueChoice HealthPlan. •As a future process improvement, the Healthy Blue/BlueChoice HealthPlan Compliance Department will conduct provider directory audits, with the assistance of two new Managers, expected to be hired by end of 3rd Quarter 2021. Results of this audit will be shared with the Provider Data team to make updates to data as needed, or as additional verification of data. The Compliance Department's audits will be in addition to audits/analyses currently performed by the Provider Data Management team.	

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

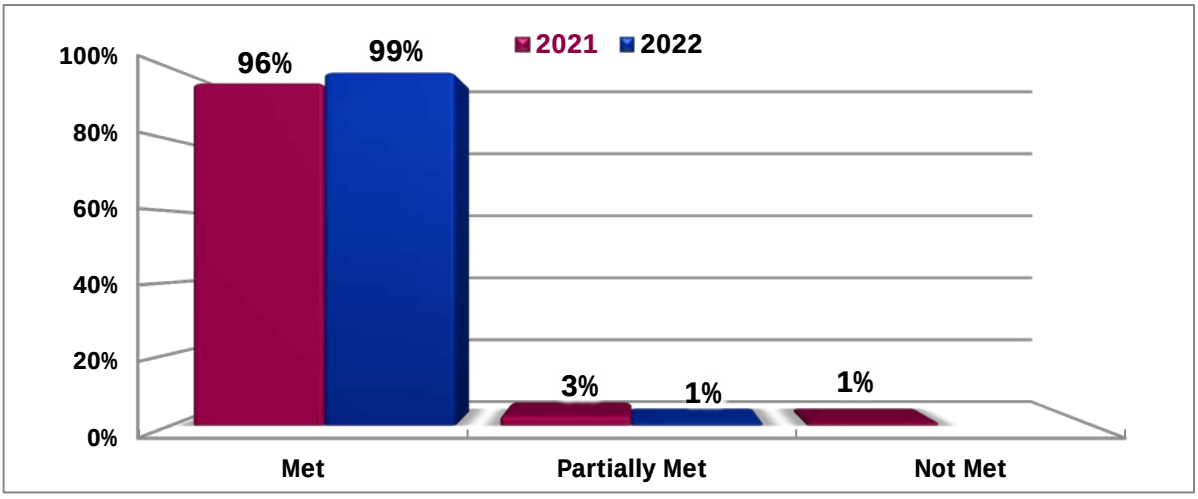
Initial provider orientation and education about Healthy Blue's MCO Program and Medicaid requirements are conducted at initial contracting. Comprehensive resources for providers include the Provider Manual and the plan's website. Providers may contact the health plan as needed for additional information. Healthy Blue conducts ongoing provider education via on-site and/or virtual sessions. Ongoing provider education provisions also include educational/reference materials, website updates, and special mailings. Healthy Blue holds regional provider training sessions throughout the state at least annually.

Healthy Blue adopts preventive health guidelines (PHGs) and clinical practice guidelines (CPGs) for physical and behavioral health from nationally recognized source organizations. Adopted guidelines are reviewed at least annually and when pertinent or new evidence is available. The adopted guidelines are relevant to health plan membership. Information about the PHGs and CPGs is included in the Provider Manual. The guidelines are posted on Healthy Blue's website, and printed copies are available upon request. Provider compliance with the guidelines is assessed through medical record audits, and through monitoring of utilization data and HEDIS gap-in-care data.

Healthy Blue educates network providers about medical record documentation standards and assesses provider compliance through annual Medical Record Compliance Audits for a sample of PCPs. Policy SC_QMXX_105 defines the scoring expectation for medical record audits as well as processes followed for substandard performance. For the 2021 Medical Record Compliance Audit, 96.9% of the providers received passing scores. Results were reported to the Clinical Quality Improvement Committee (CQIC) in April 2022.

As noted in *Figure 4: Provider Services Findings*, 99% of the Provider Services standards were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding

Table 12: Provider Services Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Credentialing and Recredentialing	Initial credentialing—Verification of information on the applicant, including: Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Partially Met	Met
	Recredentialing—Verification of information on the applicant, including: Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Partially Met	Met
Adequacy of the Provider Network	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Met	Partially Met

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- 100% of the initial credentialing and recredentialing files were compliant with all credentialing requirements for practitioners and organizational providers.
- The Network Growth Report for MY 2021, dated March 10, 2022, indicates an increase of approximately 900 network providers from January to December 2021.
- For the Telephonic Provider Access Study CCME conducted, calls were answered successfully 69% of the time.
- Ongoing provider education is conducted via on-site and/or virtual sessions and regional provider training sessions are held throughout the state at least annually. Health plan staff reported recent updates to the format for the regional trainings that allows providers to attend only the sessions that are of most interest and reported good attendance at the sessions.
- For the 2021 Medical Record Compliance Audit, 96.9% of the providers received passing scores. Only two providers required reaudit.

Weaknesses

- Healthy Blue staff reported during onsite discussion that providers can appeal any determination to deny credentialing or recredentialing. However, item 11 of Policy MCD—04, Initial Credentialing, indicates circumstances under which a provider may not appeal credentialing/recredentialing determinations.
- Policy MCD-21, Provider Directory, lists elements that must be included in the printed Provider Directory; however, it does not include office hours and age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1*.
- Policy MCD-11, Medicaid Access/Availability Standard, includes a "Physician Office Accessibility Standards" table on page four that includes an appointment access standard for routine care (within four weeks of request) and also includes an appointment access standard for "Health Maintenance and Preventative Care" (within eight weeks). Page 115 of the Provider Manual also lists the standard for Health Maintenance and Preventative Care. Healthy Blue staff were unable to differentiate between routine care and health maintenance/preventive care and confirmed this standard is not monitored. Also, the policy does not address the requirement from the

SCDHHS Contract, Section 6.2.2.3.5, that "Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures."

Quality Improvement Plans

- Revise Policy MCD-11 to remove the appointment standard for Health Maintenance and Preventative Care. Include information that walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Recommendations

- Update Policy MCD-04 to clarify when/if providers may appeal decisions to deny credentialing and recredentialing determinations.
- Revise Policy MCD-21, Provider Directory, to include office hours and age groups as required elements of the print version of the Provider Directory.

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

Member rights and responsibilities are outlined in Policy SC_ QMXX_104, Member Rights and Responsibilities. Members are informed of these rights and responsibilities in the Member Handbook and on Healthy Blue's website.

Policy SC_COXX_126, Annual Notification to Members, describes Healthy Blue's approach to notifying members of their covered services and benefits. The Benefits Quick Reference Guide describes covered services with coverage limits and exclusions. Additionally, benefit information is noted on the website and members can contact the Customer Care Center for information and assistance. During the previous EQR, CCME found that the Evidence of Coverage Change Control log did not include a date indicating when changes occurred. CCME issued a Recommendation to add the revision dates to the change control log. Healthy Blue implemented this Recommendation and added the revision dates for the changes made.

Healthy Blue educates members about available Disease Management (DM) programs in the Member Handbook. Information includes that DM staff can help members manage their conditions and that the program is free for members. The handbook lists the different conditions for which DM programs are available, the activities that will be conducted to assist members in managing applicable conditions, and how to request DM services. Information about DM services is also available on the Healthy Blue website.

Member Satisfaction Survey

Member Satisfaction Survey validation for Healthy Blue was conducted based on the CMS Survey Validation Protocol. The health plan conducts a formal annual assessment of member satisfaction that meets all the requirements of the protocol. Healthy Blue contracts with the Center for the Study of Services, a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey vendor, to conduct both the child and adult satisfaction surveys.

The analysis and implementation of interventions to improve member satisfaction is conducted by the Service Quality Improvement Committee and the CQIC. Healthy Blue submitted committee meetings and analysis-related documentation in the desk materials. The child survey met the minimum sample size of 411 valid surveys with a total of 452 completed out of 2,673. The response rate was 17.07%, which is a large increase from the previous year's rate of 8.96%. The child with chronic conditions survey sample was below the target of 411, with 362 completed surveys out of 1650 for a response rate of 22.24%. This is a substantial increase from the previous year's rate of 10.12%. The adult survey response rate was 11.99%, which was an increase from last year's response rate of 10.6%.

Grievances

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

Policy SC_GAXX 015, Grievance and Appeals for Members, the Member Handbook, and the Healthy Blue website outline procedures for receiving and resolving member grievances. Grievances are consistently and appropriately defined in policy as "An expression of dissatisfaction about any matter other than an adverse benefit determination." Members are made aware that a grievance may be filed verbally or in writing at any time. Members may also authorize a relative, a representative, or a health care practitioner or provider to represent them. A written acknowledgement of the member's grievance is sent within five calendar days of receipt of the grievance, with resolution occurring within 90 calendar days. A 14-day extension is available if requested to complete the resolution of a grievance investigation. All grievances related to clinical issues are sent to a clinical associate for review and appropriate action.

CCME reviewed a sample of grievance files and found that three of the files did not meet Healthy Blue's Policy SC_GAXX-015 for sending a written acknowledgement within five calendar days.

The graph below indicates that 97% of the standards received a "Met" score for the 2022 EQR, with 3% receiving a "Partially Met" score.

Figure 5: Member Services Findings

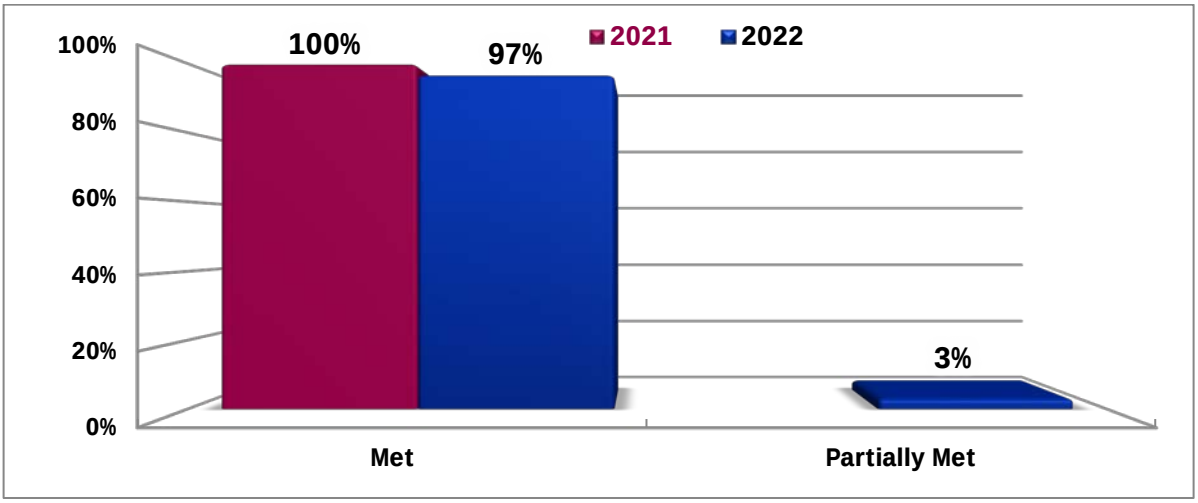


Table 13: Member Services Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Grievances	The MCO applies grievance policies and procedures as formulated	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- The response rates for the member satisfaction surveys showed an increase from the previous year's response rate.
- Grievances files reviewed demonstrated Healthy Blue resolves grievances within the required timeframe.

Weaknesses

- Three of the grievance files did not meet Healthy Blue's Policy SC_GAXX-015 for sending a written acknowledgement within five calendar days.

Quality Improvement Plans

- Conduct an internal audit of files to ascertain compliance with Healthy Blue's grievance policy. Address any deficiencies with staff to determine interventions needed to improve performance.

D. Quality Improvement

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

The 2022 Medicaid Quality Management Program Description was submitted for review. This program description is updated annually and submitted to the Clinical Quality Improvement Committee for approval. The Quality Improvement (QI) Program Description describes the scope, goals, objectives, structure, and functions for the plan. Healthy Blue provides information to members and providers about the QI Program via the Provider Manual, Member Handbook, and on the website. The website contained information regarding the 2021 HEDIS and CAHPS rates, projects underway, goals for 2022, and how a member or provider can obtain more information.

Healthy Blue develops an annual Work Plan. CCME requested and received the 2021 and 2022 Work Plans. The Work Plans included the activities for the year, objectives, frequency, responsible party, completion date, and updates or comments. The tab labeled Contracts and Dashboards was blank on the 2021 Work Plan. It did not include the benchmark/goal; nor did it record any quarterly updates. Also, the Contract and Dashboard tab was missing in the 2022 Work Plan. Healthy Blue staff mentioned changes were made to the Work Plan based on NCQA changes, and the Contract and Dashboard tab was removed in the 2022 Work Plan.

The Managed Care Oversight Committee provides oversight of quality across all lines of business for Healthy Blue. This committee reports directly to the Board of Directors. The development, implementation, monitoring, and evaluation of the QI Program is delegated to the CQIC. The CQIC provides oversight for Healthy Blue's efforts to measure, manage, and improve the quality of care and services delivered to members, and evaluates the effectiveness of the QI Program. Primary responsibilities are included in the committee charter.

CQIC membership is composed of both health plan staff and external contracting providers. Meetings are co-chaired by the Healthy Blue Medical Director and the Assistant Vice President, Medicaid. Voting members include seven actively participating providers who specialize in family medicine, OB/GYN, pediatrics, emergency medicine, and psychiatry. A meeting quorum is met with the attendance of three contracting providers. The July 2021 meeting minutes reflected a lack of a quorum of voting members present. The minutes indicated documents requiring approval would be sent to members electronically. The minutes further specified the documents were sent electronically on July 27th and were approved as of July 30th.

The CQIC meets at a minimum of four times per year. Minutes received validated the CQIC met four times in 2021, specifically in January, April, July, and October.

Healthy Blue evaluates the overall effectiveness of the QI Program and reports this assessment to the CQIC. The health plan provided CCME with the 2020 Medicaid Quality Management Program Evaluation. The program evaluation included the results of all completed activities conducted in 2020. The health plan uses the results of the evaluation to develop recommendations for improvement and priorities for the upcoming year. CCME did not identify any issues with the program evaluation.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. The performance measure validation found that Healthy Blue was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures for the current measure year (2020), as well as the previous measure year (2019) and the change from 2019 to 2020 are reported in *Table 14: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial (>10%) improvement and rates shown in red indicate a substantial (>10%) decline.

Table 14: HEDIS Performance Measure Results

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	80.29%	75.00%	-5.29%
Counseling for Nutrition	67.15%	63.66%	-3.49%
Counseling for Physical Activity	62.53%	62.37%	-0.16%
Childhood Immunization Status (cis)			
DTaP	75.91%	70.07%	-5.84%
IPV	88.08%	86.13%	-1.95%
MMR	88.08%	87.83%	-0.25%
HiB	83.45%	82.00%	-1.45%
Hepatitis B	89.29%	82.73%	-6.56%
VZV	87.83%	86.62%	-1.21%
Pneumococcal Conjugate	78.10%	73.72%	-4.38%
Hepatitis A	83.70%	87.10%	3.40%
Rotavirus	71.29%	72.26%	0.97%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Influenza	41.85%	45.99%	4.14%
Combination #2	71.53%	64.72%	-6.81%
Combination #3	69.59%	63.26%	-6.33%
Combination #4	67.88%	63.02%	-4.86%
Combination #5	60.10%	55.96%	-4.14%
Combination #6	36.50%	35.04%	-1.46%
Combination #7	59.12%	55.72%	-3.40%
Combination #8	36.25%	35.04%	-1.21%
Combination #9	32.60%	31.39%	-1.21%
Combination #10	32.36%	31.39%	-0.97%
Immunizations for Adolescents (ima)			
Meningococcal	72.02%	69.10%	-2.92%
Tdap/Td	83.21%	79.08%	-4.13%
HPV	29.68%	30.41%	0.73%
Combination #1	71.29%	68.86%	-2.43%
Combination #2	28.71%	28.95%	0.24%
Lead Screening in Children (lsc)	72.99%	72.02%	-0.97%
Breast Cancer Screening (bcs)	53.28%	51.00%	-2.28%
Cervical Cancer Screening (ccs)	57.61%	59.12%	1.51%
Chlamydia Screening in Women (chl)			
16-20 Years	53.38%	52.76%	-0.62%
21-24 Years	61.82%	59.22%	-2.60%
Total	56.20%	55.56%	-0.64%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
3-17 years	86.49%	86.18%	-0.31%
18-64 years	74.28%	73.95%	-0.33%
65+ years	NA*	NA*	NA
Total	83.94%	83.53%	-0.41%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	25.79%	29.61%	3.82%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	58.53%	69.00%	10.47%
Bronchodilator	74.68%	78.05%	3.37%
Asthma Medication Ratio (amr)			
5-11 Years	80.43%	86.06%	5.63%
12-18 Years	72.65%	73.56%	0.91%
19-50 Years	49.21%	55.97%	6.76%
51-64 Years	55.22%	51.39%	-3.83%
Total	70.40%	73.47%	3.07%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	52.80%	48.18%	-4.62%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NA*	77.14%	NA
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	78.41%	77.18%	-1.23%
Statin Adherence 80% - 21-75 years (Male)	62.36%	59.68%	-2.68%
Received Statin Therapy - 40-75 years (Female)	75.00%	77.73%	2.73%
Statin Adherence 80% - 40-75 years (Female)	55.56%	58.54%	2.98%
Received Statin Therapy - Total	76.85%	77.43%	0.58%
Statin Adherence 80% - Total	59.32%	59.14%	-0.18%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (18-64)	NR	1.14%	NA
Cardiac Rehabilitation - Engagement1 (18-64)	NR	0.57%	NA
Cardiac Rehabilitation - Engagement2 (18-64)	NR	0%	NA
Cardiac Rehabilitation - Achievement (18-64)	NR	0%	NA
Cardiac Rehabilitation - Initiation (65+)	NR	NA*	NA
Cardiac Rehabilitation - Engagement1 (65+)	NR	NA*	NA
Cardiac Rehabilitation - Engagement2 (65+)	NR	NA*	NA
Cardiac Rehabilitation - Achievement (65+)	NR	NA*	NA
Cardiac Rehabilitation - Initiation (Total)	NR	1.14%	NA
Cardiac Rehabilitation - Engagement1 (Total)	NR	0.57%	NA
Cardiac Rehabilitation - Engagement2 (Total)	NR	0%	NA
Cardiac Rehabilitation - Achievement (Total)	NR	0%	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	86.86%	84.43%	-2.43%
HbA1c Poor Control (>9.0%)	46.47%	51.09%	4.62%
HbA1c Control (<8.0%)	44.04%	44.28%	0.24%
Eye Exam (Retinal) Performed	41.12%	35.52%	-5.60%
Blood Pressure Control (<140/90 mm Hg)	56.69%	49.15%	-7.54%
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (18-64)	NR	21.93%	NA
Kidney Health Evaluation for Patients With Diabetes (65-74)	NR	NA*	NA

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Kidney Health Evaluation for Patients With Diabetes (75-85)	NR	NA*	NA
Kidney Health Evaluation for Patients With Diabetes (Total)	NR	21.93%	NA
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	63.99%	61.79%	-2.20%
Statin Adherence 80%	52.38%	49.43%	-2.95%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	50.38%	49.78%	-0.60%
Effective Continuation Phase Treatment	31.71%	33.59%	1.88%
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	42.08%	36.55%	-5.53%
Continuation and Maintenance (C&M) Phase	56.32%	46.91%	-9.41%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	66.22%	71.70%	5.48%
6-17 years - 7-Day Follow-Up	40.09%	52.09%	12.00%
18-64 years - 30-Day Follow-Up	50.35%	53.66%	3.31%
18-64 years - 7-Day Follow-Up	27.02%	32.77%	5.75%
65+ years - 30-Day Follow-Up	NA*	NA*	NA
65+ years - 7-Day Follow-Up	NA*	NA*	NA
Total - 30-Day Follow-Up	55.73%	59.46%	3.73%
Total - 7-Day Follow-Up	31.45%	38.99%	7.54%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	68.38%	66.82%	-1.56%
6-17 years - 7-Day Follow-Up	48.43%	47.47%	-0.96%
18-64 years - 30-Day Follow-Up	47.60%	43.80%	-3.80%
18-64 years - 7-Day Follow-Up	31.58%	31.13%	-0.45%
65+ years - 30-Day Follow-Up	NA	NA	NA
65+ years - 7-Day Follow-Up	NA	NA	NA
Total - 30-Day Follow-Up	56.85%	52.41%	-4.44%
Total - 7-Day Follow-Up	39.09%	37.24%	-1.85%
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (13-17)	NR	25%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (13-17)	NR	12.50%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (18-64)	NR	35.75%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (18-64)	NR	25.12%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (65+)	NR	NA*	NA

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (65+)	NR	NA*	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	NR	35.35%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	NR	24.65%	NA
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
13-17 years - 30-Day Follow-Up	NA*	12.12%	NA
13-17 years - 7-Day Follow-Up	NA*	6.06%	NA
18+ - 30-Day Follow-Up	20.09%	17.52%	-2.57%
18+ - 7-Day Follow-Up	14.18%	12.61%	-1.57%
Total - 30-Day Follow-Up	19.46%	17.17%	-2.29%
Total - 7-Day Follow-Up	13.65%	12.18%	-1.47%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	73.43%	74.27%	0.84%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	65.36%	59.76%	-5.60%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NA*	60%	NA
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	29.02%	40.89%	11.87%
65+ years	NA	NA*	NA
Total	29.02%	40.89%	11.87%
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	62.24%	60%	-2.24%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - 1-11 Years	44.83%	37.39%	-7.44%
Cholesterol Testing - 1-11 Years	25.29%	29.57%	4.28%
Blood glucose and Cholesterol Testing - 1-11 Years	25.29%	26.96%	1.67%
Blood glucose testing - 12-17 Years	55.70%	50%	-5.70%
Cholesterol Testing - 12-17 Years	32.91%	22.43%	-10.48%
Blood glucose and Cholesterol Testing - 12-17 Years	29.11%	21.50%	-7.61%
Blood glucose testing - Total	51.84%	45.59%	-6.25%
Cholesterol Testing - Total	30.20%	24.92%	-5.28%
Blood glucose and Cholesterol Testing - Total	27.76%	23.40%	-4.36%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	0.37%	0.61%	0.24%
Appropriate Treatment for Children With URI (uri)			
3months-17 Years	87.79%	88.55%	0.76%
18-64 Years	67.58%	72.36%	4.78%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
65+ Years	NA*	NA*	NA
Total	85.12%	86.36%	1.24%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
3 months-17 Years	57.85%	59.98%	2.13%
18-64 Years	31.98%	31.12%	-0.86%
65+ Years	NA*	NA*	NA
Total	49.28%	51.18%	1.90%
Use of Imaging Studies for Low Back Pain (lbp)	69.62%	70.77%	1.15%
Use of Opioids at High Dosage (hdo)	5.05%	3.41%	-1.64%
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	22.84%	20.06%	-2.78%
Multiple Pharmacies	3.89%	3.25%	-0.64%
Multiple Prescribers and Multiple Pharmacies	2.46%	1.95%	-0.51%
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	2.74%	4.00%	1.26%
18-64 years - >=31 Days covered	2.26%	3.10%	0.84%
65+ years - >=15 Days covered	NA	NA	NA
65+ years - >=31 Days covered	NA	NA	NA
Total - >=15 Days covered	2.74%	4%	1.26%
Total - >=31 Days covered	2.26%	3.10%	0.84%
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	76.21%	74.75%	-1.46%
45-64 Years	85.13%	83.61%	-1.52%
*65+ Years**	NA*	100%	NA
Total	78.73%	76.80%	-1.93%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA*	39.29%	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA*	10.71%	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA*	NA*	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA*	NA*	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	36.84%	42.24%	5.40%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	14.29%	10.34%	-3.95%
Initiation of AOD Treatment: 13-17 Years	36.99%	39.85%	2.86%

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Engagement of AOD Treatment: 13-17 Years	13.01%	9.77%	-3.24%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	38.50%	41.88%	3.38%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	8.72%	6.57%	-2.15%
Opioid abuse or dependence: Initiation of AOD Treatment: 18+ Years	52.14%	56.79%	4.65%
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	24.18%	35.41%	11.23%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	39.64%	40.78%	1.14%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	10.16%	9.44%	-0.72%
Initiation of AOD Treatment: 18+ Years	40.78%	43.85%	3.07%
Engagement of AOD Treatment: 18+ Years	11.87%	13.80%	1.93%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	38.52%	41.79%	3.27%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	8.58%	6.72%	-1.86%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	52.24%	56.29%	4.05%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	24.13%	35.10%	10.97%
Other drug abuse or dependence: Initiation of AOD Treatment: Total	39.31%	40.92%	1.61%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	10.65%	9.52%	-1.13%
Initiation of AOD Treatment: Total	40.49%	43.61%	3.12%
Engagement of AOD Treatment: Total	11.95%	13.56%	1.61%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.98%	87.59%	-3.39%
Postpartum Care	70.22%	78.10%	7.88%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
1-11 Years	50.00%	58.97%	8.97%
12-17 Years	60.00%	67.19%	7.19%
Total	56.20%	64.08%	7.88%
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)	NR	47.33%	NA
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	NR	71.17%	NA
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (3-11)	NR	47.01%	NA
Child and Adolescent Well-Care Visits (12-17)	NR	40.23%	NA
Child and Adolescent Well-Care Visits (18-21)	NR	17.48%	NA

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	PERCENTAGE POINT DIFFERENCE
Child and Adolescent Well-Care Visits (Total)	NR	41.90%	NA

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

Healthy Blue produces HEDIS rates using software from an NCQA-certified measure vendor. The comparison from the previous year to the current year revealed a greater than 10% increase in six measures and one measure, Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) cholesterol testing for 12 to 17 year olds had a substantial decline of more than 10%. *Table 15* highlights the HEDIS measures with substantial changes in rate from last year to the current year.

Table 15: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	Measure Year 2019	Measure Year 2020	Change from 2019 to 2020
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	58.53%	69%	10.47%
Follow-Up After Hospitalization for Mental Illness (fuh) -			
6-17 years - 7-Day Follow-Up	40.09%	52.09%	12.00%
Pharmacotherapy for Opioid Use Disorder (pod)			
16-64 years	29.02%	40.89%	11.87%
Total	29.02%	40.89%	11.87%
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	24.18%	35.41%	11.23%
Opioid abuse or dependence: Engagement of AOD Treatment: Total	24.13%	35.10%	10.97%
Substantial Decrease in Rate (>10% decrease)			
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Cholesterol Testing - 12-17 Years	32.91%	22.43%	-10.48%

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

CCME validated the Performance Improvement Projects (PIPs) following the CMS-developed protocol titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." The protocol validates components of the project and its

documentation to provide an assessment of the overall study design and methodology of the project. The components assessed are as follows:

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

Healthy Blue submitted two PIPs for validation. The Comprehensive Diabetes Care PIP and a new PIP, CAHPS – Child with Chronic Conditions Customer Service PIP. The PIPs met the validation requirements and received scores within the "High Confidence Range." The tables that follow provide an overview of the previous validation scores with the current scores and a summary of interventions for each project.

Table 16: Comprehensive Diabetes Care PIP

Comprehensive Diabetes Care	
The aim for the Comprehensive Diabetes Care PIP is to increase the percentage of members who receive HbA1c and retinal eye exams. Both indicators showed baseline rates. The HbA1C >9% rate was 51.09% with a goal of 58.75%. The Retinal eye exam indicator rate was 35.35% with a goal of 37.35%.	
Previous Validation Score	**Current Validation Score**
100/100=100% High Confidence in Reported Results	93/93= 100% High Confidence in Reported Results
Interventions	
• Targeted text messages and outreach calls to members who have been diagnosed as being Diabetic to ensure the member has their HbA1c screenings and Diabetic Retinal Eye Exams. • Members that become compliant on the following services - A1c test, eye exam, and completion of diabetes survey - will be able to choose gift cards from various platforms. In addition to gift cards, members can receive fresh fruits and vegetables. • Practice Consultants visit (webinars) providers, review their current Gap in Care, provide a PowerPoint presentation with HEDIS information, and answer any questions that the provider may have. • Case Managers offer members assistance with PCP appointments, pharmacy and any Social Determinants of Health needs.	

Table 17: CAHPS – Child with Chronic Conditions Customer Service PIP

CAHPS – Child with Chronic Conditions Customer Service
The aim for this PIP is to improve the Child CAHPS measure: Customer Service Provided Information/Help. This PIP was selected to help measure and improve quality of service and member satisfaction on the Child with Chronic Conditions Survey. The baseline rate was 81.08% with a goal of 67th percentile of NCQA Quality Care Compass.

CAHPS – Child with Chronic Conditions Customer Service	
Previous Validation Score	**Current Validation Score**
Not Submitted	88/93= 95% High Confidence in Reported Results
Interventions	
• Oversampling • Provide a Spanish Survey	

CCME noted the current interventions seem focused on improving response rates and reaching a larger audience, but not necessarily improving customer service scripts or resources. CCME provided the following recommendation for the Improving Encounters Acceptance Rates PIP listed in *Table 18*.

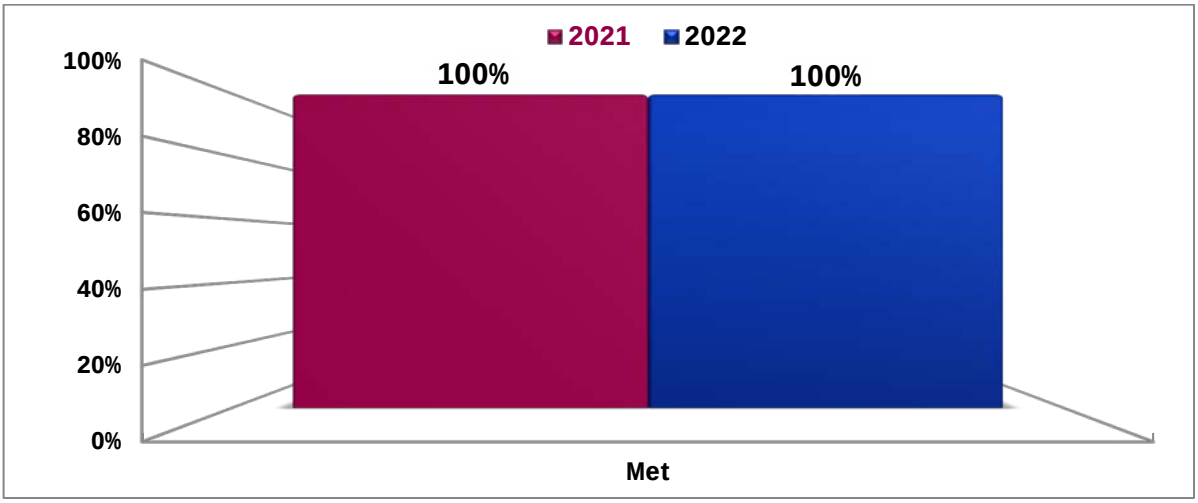
Table 18: CAHPS – Child with Chronic Conditions Customer Service Recommendation

Project	Section	Reason	Recommendation
CAHPS – Child with CCC Customer Service	Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken?	Interventions and barriers are reported but do not appear to be linked directly to the indicator for the PIP.	Include interventions that directly address improving customer service.

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

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

Figure 6: Quality Improvement Findings



Strengths

- The following HEDIS MY 2020 measure rates were strengths for Healthy Blue since their rates had a greater than 10% improvement:
  - Pharmacotherapy Management of COPD Exacerbation (pce), Systemic Corticosteroid improved 10.47% from last year.
  - Follow-Up After Hospitalization for Mental Illness (FUH), 6-17 years – 7-Day Follow-Up improved 12.00%.
  - Pharmacotherapy for Opioid Use Disorder (pod), 16-64 years and Total improved almost 12%.
- All performance improvement projects scored within the "High Confidence" range for the reported results.

Weaknesses

- CCME noted the current interventions for the CAHPS PIP seemed focused on improving response rates and reaching a larger audience, but not necessarily improving customer service scripts or resources.

Recommendations

- Include interventions in the CAHPS – Child with Chronic Conditions Customer Service PIP that directly address improving customer service.

E. Utilization Management

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

Healthy Blue provided the 2022 Utilization Management Program Description, titled Utilization Management (UM) Program Description Template 2022, for review. The UM Program Description and several policies and documents guide staff in conducting UM functions. The UM Program Description was last reviewed and approved in April 2022.

The UM Program Description describes the Chief Medical Officer's (CMO) role and responsibilities. For Healthy Blue, Dr. Imtiaz Khan oversees all aspects of the UM Program. The Behavioral Health Medical Director provides oversight and expertise for behavioral health services.

Healthy Blue evaluates the UM Program annually. Results and recommendations are presented to the Quality Improvement Committees as applicable. Healthy Blue provided the UM Program Evaluation covering measurement year 2021 as evidence of this evaluation.

Healthy Blue's screening criteria are based upon nationally recognized standards of UM practice. The Medical Policy and Technology Assessment Committee (MPTAC) and the CQIC annually review and approve the criteria. Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, and Policy and Procedure Clinical Criteria for Utilization Management Decisions – Core Process, discuss the process for applying criteria and disseminating criteria to members and providers as requested. UM staff receive updates regarding interpretation and application of the criteria guidelines. The health plan provides quarterly updates via email, departmental meetings, and as changes to UM, decision criteria guidelines, and policies and procedures occur. UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.

Requests for medical services that do not meet medical necessity criteria or require further medical review are routed to a Peer Clinical Reviewer. Only licensed physicians are able to deny a medical service or treatment.

The UM Program Description, Policy SC_UMXX_120, Nurse Inter-Rater, and Policy SC UMXX 078, Physician Inter-Rater Reliability Assessment, describe the process Healthy Blue uses to evaluate the quality and consistency of clinical decisions among reviewers. The nurse reviewers, medical directors and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually. Results are reported to the Services Quality Improvement Committee (SQIC) and the CQIC. The benchmark or goal is 90%. Scores below 90% require documented re-education, re-testing, and auditing.

Results of the 2021 IRR were reported in the UM Program Evaluation, which also identified barriers and opportunities for improvements.

The Pharmacy Program Description explains that IngenioRx is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities. Healthy Blue's website contains information regarding covered prescriptions including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change document found on the website included the effective date, the product name, and the changes made. It was not clear when the changes were posted to the website. The Pharmacy Program Description, page 10, indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the *SCDHHS C*ontract, *Sections 4.2.21.2.1* and *4.2.21.3,* requires the change be published on the website at least 30 days prior to implementation.

A policy is in place to ensure that Healthy Blue monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization, which may impact health care services, coordination of care, and appropriate use of services and resources. Healthy Blue analyzed and monitored data, and offered recommendations based on findings for the several services in regard to utilization in the committee meetings and 2020 Under and Over Utilization report.

The HEDIS MY2020 rate for ER visits per 1000 member months decreased from 2019 to 2020 by 18.68 percentage points and is below the NCQA's Quality Compass National thresholds of 50%. The utilization rate of 6.05 for General Hospital/Acute Care Discharges/1000 member months was within the parameters for NCQA National under and over utilization threshold limits of 5.64 - 9.54 for the Medicaid population, with a decrease of 1.08 Discharges/1000 member months from MY 2019 to MY 2020.

Appeals

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

Policy SC_GAXX_051, Member Appeal Process-SC, describes how appeals are submitted and processed. Appeal information is provided in the Member Handbook, Provider Manual, and on the website. The website also includes forms for members and providers to file an appeal.

CCME's review of appeal files concluded that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. CCME identified the following issues with the appeal files:

- Healthy Blue's Policy SC_GAXX_051, Member Appeal Process, indicates the member or authorized representative is mailed a copy of the case file within 10 calendar days of receipt of the appeal. There were nine files for which the case file was not sent within the 10-day timeframe or was not sent at all. This was an issue identified during the 2021 EQR.
- Three files required the member to submit the appeal request in writing after requesting the appeal orally even though this is no longer a requirement.
- The physician who made the appeal decision for three files was neither the same physician nor had a similar specialty as the requesting provider.

During the 2021 EQR, CCME noted that Healthy Blue was not consistently following Policy SC_GAXX_051, Member Appeal Process-SC, regarding the member's appeal case file. Healthy Blue addressed this deficiency as noted in *Table 19: Previous Deficiencies and Quality Improvement Plan*. However, the file review determined this deficiency was not resolved.

Table 19: Previous Deficiencies and Quality Improvement Plan

Standard	EQR Comments
Appeals	
2. The MCO applies the appeal policies and procedures as formulated.	Review of appeals files reflected Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. The following issues were noted: •Two versions of appeal case file letters were utilized; one version instructed members to respond with additional information within 10 calendar days from the date on the letter and the other version did not provide a timeframe to respond. During the onsite Healthy Blue staff explained appeal case letters were updated in January 2021, to include instructions for members to respond with additional information within 10 calendar days from the date on the letter. This update was a recommendation from the 2020 EQR. •Appeal case files were not sent to members within 10 calendar days, as stated on page four of Policy SC_GAXX_051, Member Appeal Process, thus not allowing adequate time for the member to respond prior to the determination. •Inconsistencies with obtaining member consent when an appeal was requested from a provider. *Quality Improvement Plan: Follow processes in Policy SC_GAXX_051, Member Appeal Process to ensure appeal case file letters are mailed to members within 10 days of receiving the appeals request and to ensure member consent is obtained when an appeal is requested from a someone other than the member.*

Standard	EQR Comments
Healthy Blue Response: The following process updates have been taken to ensure the appeal policy is followed: •The updated Case File letter (stating member has 10 days to give additional information) is loaded into the electronic appeals system (PEGA) as of 1/2021. The previous case file letter has been retired from the system. •To ensure case files are sent timely, the responsibility of generating case files has been given to the triage team. The triage team checks the work basket for all new appeals to verify the appeal is entered correctly and acknowledgement letter has been sent. As part of this process, the triage team will ensure case files are created and sent to members within 10 calendar days from the receipt date of the appeal, as stated in Policy SC_GAXX_051, Member Appeal Process. •To ensure member consent is obtained, the triage team will make outbound calls to both the provider and member for consent. If consent is not obtained by the triage team, the nurse assigned to the case will make a second set of outbound calls to provider and member for consent. If consent is not obtained after reasonable effort, the appeal will be dismissed.	

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

The Complex Case Management 2021-2022 Program Description (CM Program Description) and the 2022 Population Health Program Description address various aspects of the program, including its mission, vision, goals and objectives, lines of responsibility and accountability, staffing credentials, and training requirements. Associated policies and procedures provide staff with detailed information for conducting CM activities.

The health plan identifies members as candidates for CM services through methods that include internal and external referrals, predictive modeling, data mining, and health risk assessments. Specific diagnosis and/or procedure codes may trigger a referral for CM services. Also, all newly enrolled members receive a printed Health Risk Screening form to complete and return to the health plan. Healthy Blue staff reported good response rates to the mailed screening forms.

All members are stratified into five levels using predictive modeling. For members with the most complex needs, a second predictive model is applied that ranks members on their likelihood of an inpatient admission within 60 days and future care costs. The stratification levels rank members from lowest risk (Group 0) to highest risk (Group 4) so that appropriate CM activities and interventions are included in the plan of care and management of the member.

The review of a sample of physical health and behavioral health CM files confirmed appropriate activities are conducted to manage members in the CM Program. No issues were identified.

Healthy Blue conducts an annual CM Program evaluation to assess the efficiency and effectiveness of the program and to monitor year-over-year performance and outcomes,

including identification and engagement, participation rates, program satisfaction, and results of program clinical measures. The evaluation informs process improvement activities to address any identified inefficiencies or problem areas. Member satisfaction with the CM Program is evaluated through a vendor-conducted telephonic survey process. The health plan reviews survey results quarterly to identify trends and opportunities for improvement.

As noted in *Figure 7: Utilization Management Findings*, Healthy Blue achieved "Met" scores for 96% of the UM standards and 4% were scored as "Partially Met."

Figure 7: Utilization Management Findings

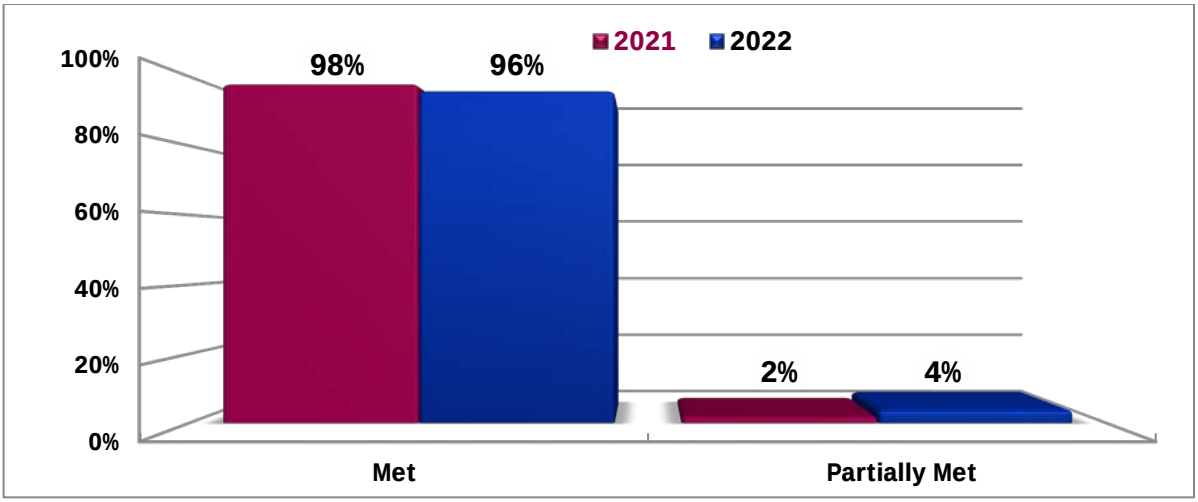


TABLE 20: Utilization Management Comparative Data

SECTION	STANDARD	2021 REVIEW	2022 REVIEW
Medical Necessity Determinations	Pharmacy Requirements Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2021 to 2022.

Strengths

- Utilization management decisions were timely, and members were notified of these decisions appropriately.
- UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.

- Consistent application of UM medical necessity criteria is monitored via participation by physicians and licensed clinical staff in Inter-Rater Reliability testing.
- Case Management program descriptions and policies thoroughly document processes and activities to identify members as potential candidates for CM services, as well as member assessment, care plan development, and ongoing monitoring activities.
- Member satisfaction with the Complex Case Management Program is evaluated through a telephonic survey process, and survey results are reviewed quarterly to identify trends and opportunities for improvement. Results are also considered in the annual CM Program evaluation conducted to assess the efficiency and effectiveness of the program. The program evaluation informs process improvement activities to address any identified inefficiencies or problem areas.

Weaknesses

- The Preferred Drug List change document found on the website did not include the date the change was published on the website. Also, page 10 of the Pharmacy Program Description indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the *SCDHHS Contract* requires the change be published on the website at least 30 days prior to implementation.
- Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process.

Quality Improvement Plans

- Update the PDL change document posted on the website and include the date the change document was posted. Also, update the Pharmacy Program Description to indicate that changes are published on the website at least 30 days prior to implementation as required by the *SCDHHS Contract, Section 4.2.21.2.1* and *4.2.21.3*.
- Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy, *SCDHHS Contract,* and federal regulations. Implement interventions to address the barriers.

F. Delegation

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

Delegation agreements are in place between Healthy Blue/Amerigroup and the entities listed in *Table 21: Delegated Entities and Services*.

Table 21: Delegated Entities and Services

Delegated Entities		Delegated Services
• CVS / CaremarkPCS • IngenioRx		Pharmacy Benefit Management
• AnMed Health • BIO-IQ • Bon Secours St. Francis • Atrium Health (CPN) • Lexington Medical Center (LMC) • Matrix Health • MUSC • Online Care Network II	• Preferred Care of Aiken • Prisma Health Upstate • Prisma Health Midlands • Regional Health Plus / SRHS • Roper St. Francis • SC DMH • Signify Health • Vision Service Plan (VSP)	Credentialing

The Delegate/Vendor Oversight and Management Program policy and procedure describes processes for delegation of health plan activities and oversight of delegated entities. The Delegation Operations Committee oversees delegation processes. The health plan subjects each potential delegate to a pre-delegation assessment to determine its capabilities for conducting functions in compliance with all requirements. Healthy Blue conducts annual oversight and ongoing monitoring for all delegates. Standardized audit tools that are specific to functional areas are used for pre-delegation and annual assessments.

Healthy Blue submitted documentation of annual and/or pre-delegation assessments conducted in the last year for all delegated entities. The documentation shows that recommendations and corrective actions were implemented with the delegates when appropriate. For credentialing delegates, the file review worksheets do not provide evidence that the delegates are assessed for compliance with the initial credentialing processing timeframe stated in the *SCDHHS Contract, Section 2.8.2.4.2*, nor for ensuring applicable providers have admitting privileges.

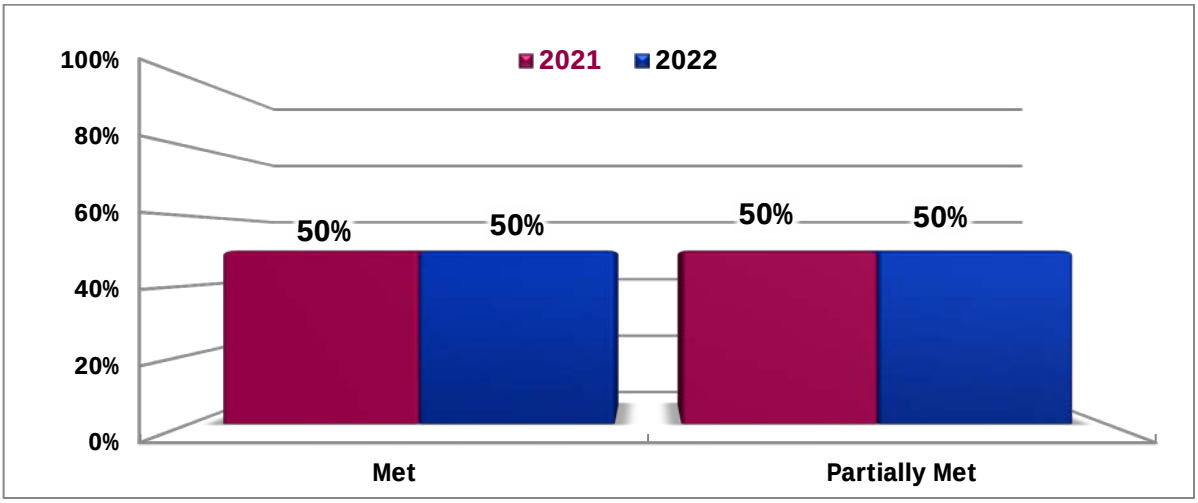
The review of delegation processes and documentation of delegate oversight confirmed Healthy Blue addressed deficiencies noted during the 2021 EQR. *Table 22: Previous Delegation QIP Items* displays the previous findings as well as Healthy Blue's response to the findings.

Table 22: Previous Delegation QIP Items

Standard	EQR Comments
Delegation	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Documentation of delegation oversight was submitted for review. The following issues were identified: •For two delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System, as stated in Policy MCD-10, Medicaid Delegated Credentialing. This is a repeat finding from the previous EQR. •For one delegate, the MCO Credentialing File Review Workbook does not indicate whether the delegate was monitored for querying the Social Security Death Master File, as stated in Policy MCD-10, Medicaid Delegated Credentialing. •For five credentialing delegates, the MCO Credentialing File Review Workbook does not indicate whether the delegates were monitored for collection of nurse practitioner collaborative agreements. *Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for conducting required queries of the National Plan and Provider Enumeration System and Social Security Death Master File, as well as collection of collaborative agreements between nurse practitioners and supervising physicians. This should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.*
Healthy Blue's response: Credentialing and Recredentialing delegates are monitored for conducting required queries. We have pre-populated the notes section of the MCO Credentialing File Review Workbook (Audit tool) used to assess credentialing delegates with the National Plan and Provider Enumeration System review, the Social Security Death Master File review, and the Collection of Nurse Practitioner Collaborative Agreements review. We have also made it mandatory for our staff auditors to use the pre-populated template when conducting future audits.	

As noted in *Figure 8: Delegation Findings*, 50% of the Delegation standards were scored as "Met."

Figure 8: Delegation Findings



Strengths

- Potential delegates are subjected to pre-delegation assessments to determine their ability to conduct functions in compliance with all requirements. Established delegates are subjected to annual oversight and ongoing monitoring.
- Pre-delegation assessments and annual assessments are conducted using standardized audit tools that are specific to functional areas.

Weaknesses

- For credentialing delegates, the file review worksheets do not provide evidence that the delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges.

Quality Improvement Plans

- Ensure credentialing and recredentialing delegates are monitored for compliance with initial credentialing timeframe requirements and for ensuring applicable providers have admitting privileges or an admitting arrangement. These elements should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.

G. State Mandated Services

42 CFR Part 441, Subpart B

Healthy Blue's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program is designed to comply with the recommendations of the American Academy of Pediatrics for the provision of health screenings and services for children through the month of their

21st birthday. Provider compliance with the recommendations for EPSDT services and immunizations is monitored through the formal Medical Record Compliance Audit process and by monitoring HEDIS performance gap-in-care data.

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

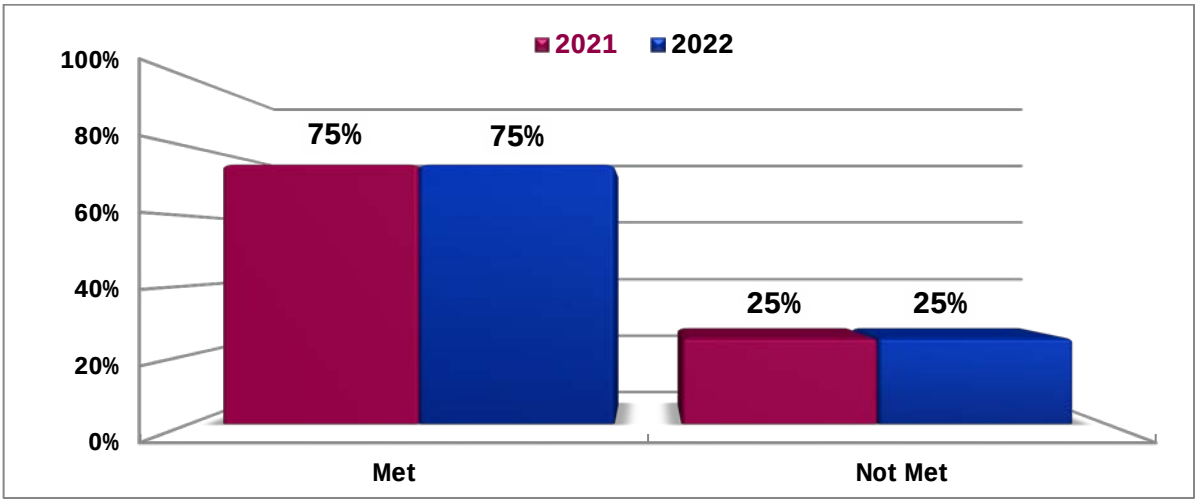
The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10-day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process. See *Table 23: Previous State Mandated Services* QIP Items for the previously identified issue and Healthy Blue's response to the finding.

Table 23: Previous State Mandated Services QIP Items

Standard	EQR Comments
State Mandated Services	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	During the previous EQR, documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Practitioner Databank and the National Plan and Provider Enumeration System. The current EQR found that documentation of oversight of credentialing delegates did not indicate whether the delegates were monitored for querying the National Plan and Provider Enumeration System. *Quality Improvement Plan: Implement quality improvement plans from the External Quality Review to address all identified deficiencies.*
Healthy Blue's Response: Healthy Blue will fully implement all Quality Improvement Plans described above, as well as address recommendations, identified in the audit report.	

As indicated in *Figure 9: State Mandated Services*, standards in the State Mandated Services section are scored as 75% "Met" and 25% "Not Met."

Figure 9: State Mandated Services



Strengths

- Healthy Blue ensures the provision of EPSDT services and immunizations recommended in the AAP Periodicity Schedules and monitors provider compliance with the recommended guidelines and services.
- Primary care providers are routinely notified of members who may not have received EPSDT services according to schedule.

Weaknesses

- The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10-day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process.

Quality Improvement Plans

- Implement Quality Improvement Plans from the EQR to address all identified deficiencies.

ATTACHMENTS

Attachment 1: Initial Notice, Materials Requested for Desk Review

Attachment 2: Materials Requested for Onsite Review

Attachment 3: EQR Validation Worksheets

Attachment 4: Tabular Spreadsheet

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

March 14, 2022

Mr. Christopher Teska
Assistant Vice President for Medicaid
Healthy Blue
PO Box 6170, Mail Code AX-400
Columbia, SC 29260-6170

Dear Mr. Teska:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2022 External Quality Review (EQR) of Healthy Blue is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The two-day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **May 11th and May 12th.** .

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **March 28, 2022.**

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

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at sowens@thecarolinascenter.org if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

1. Copies of all current policies and procedures, as well as a complete index which includes policy name, number and department owner. The date of the addition/review/revision should be identifiable on each policy.

2. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. Please provide a list of all current employees, the employees title, and credentials.

3. Current membership demographics including total enrollment and distribution by age ranges, sex, and county of residence.

4. Documentation of all service planning and provider network planning activities (e.g., copies of complete geographic assessments, provider network assessments, enrollee demographic studies, and population needs assessments) that support the adequacy of the provider base. Please include the maximum allowed and the current member-to-PCP ratios and member-to-specialist ratios.

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

Excel Spreadsheet Format

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

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

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

8. A copy of the current Compliance plan and organization chart for the compliance department. Include the Fraud, Waste, and Abuse plan if a separate document has been developed, as well as any policies/procedures related to provider payment suspensions and recoupments of overpayments, and the pharmacy lock-in program.

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

10. The Quality Improvement work plans for 2021 and 2022.

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

12. Documentation of all Performance Improvement Projects (PIPs) completed or planned since the previous Annual Review, and any interim information available for projects currently in progress. This documentation should include information from the project that explains and documents all aspects of the project cycle (i.e., analytic plans, reasons for choosing the topic, measurement definitions, interventions planned or implemented, calculated results, analysis of results for each measurement period, barriers to improvement and interventions to address each barrier, statistical analysis (if sampling was used), etc.

13. Minutes of all committee meetings in the past year reviewing or taking action on SC Medicaid-related activities. All relevant attachments (e.g., reports presented, materials reviewed) should be included. If attachments are provided as part of another portion of this request, a cross-reference is satisfactory, rather than sending duplicate materials.

14. Membership lists and a committee matrix for all committees including the professional specialty of any non-staff members. Please indicate which members are voting members and include the committee charters if available.

15. Any data collected for the purposes of monitoring the utilization (over and under) of health care services. Please provide the over and underutilization summary report(s) and the quarterly or monthly monitoring reports.

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

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

18. A complete list of all members enrolled in the case management program from April 2021 through March 2022. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

19. A copy of staff handbooks/training manuals, orientation and educational materials and scripts used by Member Services Representatives and/or Call Center personnel.

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

21. A report of findings from the most recent member and provider satisfaction surveys (i.e., CAHPS and ECHO), a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

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

23. A copy of the Grievance, Complaint and Appeal logs for the months of April 2021 through March 2022.

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

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

26. Preventive health guidelines recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

27. Clinical practice guidelines for disease and chronic illness management recommended by the MCO for use by practitioners, including references used in their development, when they were last updated, how they are disseminated and how consistency with other MCO services and covered benefits is assessed.

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

31. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. A completed ISCA. *(Not a summarized ISCA or a document that contains ISCA-like information, but the ISCA itself.)*
    b. A network diagram showing (at a minimum) the relevant components in the information gathering, storage, and analysis processes. *(We are interested in the processing of claims and data in South Carolina, so if the health plan in South Carolina is part of a larger organization, the emphasis or focus should be on the network resources that are used in handling South Carolina data.)*
    c. A flow diagram or textual description of how data moves through the system. *(Please see the comment on b. above.)*
    d. A copy of the IT Disaster Recovery Plan or Business Continuity Plan.
    e. A copy of the most recent disaster recovery or business continuity plan test results.
    f. An organizational chart for the IT/IS department and a corporate organizational chart that shows the location of the IT organization within the corporation.
    g. A copy of the most recent data security audit, if completed.
    h. A copy of the policies or program description that address the information systems security and access management. Please also include polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

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

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

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

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

36. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files (acute inpatient, outpatient and behavioral health) for the months of April 2021 through March 2022. Include any medical information and physician review documentation used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) for the months of April 2021 through March 2022, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Additional information on the attached Credentialing File request list.

3. Appeal files 11, 13, and 24 were corrupt and could not be opened. Please resubmit those files.

4. A copy of the Acknowledgement Letter for appeal file 19.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**CAHPS – CHILD WITH CHRONIC CONDITIONS CUSTOMER SERVICE - NON CLINICAL**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection reports document the consistency and accuracy of data collection instruments.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The data analysis plan is noted as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff used to collect data and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	An annual rate is reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	The results are presented accurately and clearly using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline rate only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation and interventions.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**PARTIALLY MET**	Interventions and barriers are reported but do not appear to be linked directly to the indicator for the PIP. *Recommendation: Include interventions that directly address the customer service for the family in addition to the active interventions to improve response rates.*
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate was 81.1% reporting usually or always for the item regarding customer services giving the information or help that was needed at baseline with a goal of 67th percentile NCQA All LOB.
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)**	**NA**	Baseline rate only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline rate only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	88
Project Possible Score	93
Validation Findings	95%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PIP Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PIP:	**COMPREHENSIVE DIABETES CARE - CLINICAL**
Reporting Year:	2021
Review Performed:	2022

ACTIVITY 1: ASSESS THE PIP METHODOLOGY

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

Component / Standard (Total Points)	Score	Comments
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data is collected using programming logic.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instrument reports are documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The data analysis plan is noted as annual.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Qualified staff used to collect data and project analysis are documented.
STEP 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Annual rates are reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results are presented using tables.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**NA**	Baseline rate only.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? **(1)**	**MET**	Analysis of data included rate evaluation and interventions.
STEP 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers are reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Two indicators for this PIP including A1C >9% and Eye Exam. The rate was 51.09% for A1C >9% at baseline with a goal of 37.35%. For Eye exam, the rate was 35.52% with a goal of 58.64%.
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)**	**NA**	Baseline rate only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Baseline rate only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

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

Project Score	93
Project Possible Score	93
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

Audit Designation Categories	
High Confidence in Reported Results	Little to no minor documentation problems or issues that do not lower the confidence in what the plan reports. *Validation findings must be 90%–100%.*
Confidence in Reported Results	Minor documentation or procedural problems that could impose a small bias on the results of the project. *Validation findings must be 70%–89%.*
Low Confidence in Reported Results	Plan deviated from or failed to follow their documented procedure in a way that data was misused or misreported, thus introducing major bias in results reported. *Validation findings between 60%–69% are classified here.*
Reported Results NOT Credible	Major errors that put the results of the entire project in question. *Validation findings below 60% are classified here.*

CCME EQR PM Validation Worksheet

Plan Name:	**Healthy Blue**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**MY2020**
Review Performed:	**2022**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2020

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 complete and 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 complete and accurate.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	**Met**	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1 Reporting	Were the state specifications for reporting performance measures followed?	**Met**	HEDIS specifications were followed and found compliant.
Overall assessment			Health plan uses National Committee for Quality Assurance (NCQA)-certified software application: Quality Spectrum Insight™ from Inovalon. Audit report noted compliance for HEDIS measures.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- ADULT**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	**MET**	The study population was identified. *Documentation:* CSS Adult CAHPS Summary Report 2021
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	**MET**	The sampling frame was clearly defined and appropriate. *Documentation:* CSS Adult CAHPS Summary Report 2021

Survey Element		Element Met / Not Met	Comments and Documentation
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	The sampling method was conducted according to specifications. *Documentation:* CSS Adult CAHPS Summary Report 2021
3.4	Review whether the sample size is sufficient for the intended use of the survey.	**MET**	The sample size was sufficient according to CAHPS survey guidelines. *Documentation:* CSS Adult CAHPS Summary Report 2021
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	The procedures used to select the sample were appropriate. *Documentation:* CSS Adult CAHPS Summary Report 2021

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

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

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Yes. Procedures are in place to address response issues. *Documentation:* CSS Adult CAHPS Summary Report 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Adult response rate was 11.99% which was an increase from last year's response rate of 10.6% but below the National Committee for Quality Assurance (NCQA) target response rate of 40%. *Documentation:* CSS Adult CAHPS Summary Report 2021 *Recommendation: Continue internal meetings and oversampling for response rate improvement initiatives.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to the Work Plan. *Documentation:* CSS Adult CAHPS Summary Report 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS Adult CAHPS Summary Report 2021

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD CCC**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* CSS Child CCC CAHPS Summary Report 2021
5.2	Did the implementation of the survey follow the planned approach?	**MET**	The survey implementation followed the plan. *Documentation:* CSS Child CCC CAHPS Summary Report 2021

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS Child CCC CAHPS Summary Report 2021

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS Child CCC CAHPS Summary Report 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The CCC survey sample was below the target of N=411 with 362 completed surveys out of 1650 for a response rate of 22.24% which is a substantial increase from the previous year's rate of 10.12%. However, the rate is still below the National Committee for Quality Assurance (NCQA) target response rate of 40%. . *Documentation:* CSS Child CCC CAHPS Summary Report 2021 *Recommendation: Continue internal meetings and oversampling for response rate improvement initiatives.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to the Work Plan. *Documentation:* CSS Child CCC CAHPS Summary Report 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS Child CCC CAHPS Summary Report 2021

CCME EQR Survey Validation Worksheet

Plan Name	**Healthy Blue**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2021
Review Performed	2022

Review Instructions

Identify documentation that was reviewed for the various survey activities listed below and the findings for each. If documentation is absent for a particular activity this should also be noted since the lack of information is relevant to the assessment of that activity. (updated based on October 2019 version of EQR protocol 6)

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

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

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

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

ACTIVITY 3: REVIEW THE SAMPLING PLAN

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

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

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

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* CSS Child CAHPS Summary Report 2021
5.2	Did the implementation of the survey follow the planned approach?	**MET**	The survey implementation followed the plan. *Documentation:* CSS Child CAHPS Summary Report 2021

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* CSS Child CAHPS Summary Report 2021

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

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

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* CSS Child CAHPS Summary Report 2021
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The child surveys met the minimum sample size of 411 valid surveys with a total of 452 completed out of 2,673 and the response rate was 17.07% which is a large increase from the previous year's rate of 8.96%. The *Documentation:* CSS Child CAHPS Summary Report 2021 *Recommendation: Continue internal meetings and oversampling for response rate improvement initiatives.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	The data were analyzed according to Work Plan. *Documentation:* CSS Child CAHPS Summary Report 2021
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* CSS Child CAHPS Summary Report 2021

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Healthy Blue
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	X					Policy MCD-16, Policy Development, Review, and Management, outlines Healthy Blue's approach to monitoring policies, maintaining the annual review of policies, processes for approving and disseminating policies, and ensuring that policies are accessible to all employees.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						The 2022 Organization Chart and Key Personnel List demonstrate sufficient staff are in place to ensure services required by SCDHHS are provided to members. Onsite discussion addressed the color key specific to the Organizational Chart and updates on key positions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					The President and COO Administrator is Tim Vaughn.
1.2 Chief Financial Officer (CFO);	X					The Chief Financial Officer is Jennifer Thorne.
1.3 * Contract Account Manager;	X					Amy Bennett is the Contract Account Manager.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					The Claims and Encounter Managers are Kraig Dalton (Claims) and John Hodges (Encounters).
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Director of Utilization Management is Bryan Hawkins, RN, BSN.
1.5.1 Pharmacy Director,	X					Julie Hernandez, PharmD, is the Pharmacy Director.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					There are 12 physical health case managers (11 located in South Carolina) and 5 behavioral health case managers, all located in South Carolina.
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					The Quality Improvement Manager is Shana Hunter.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.7 *Provider Services Manager;	X					Shay Looker is the Provider Services Manager.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					The Member Services Manager is Letitia Lindsay.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					The Medical Director is Dr. Imtiaz Khan.
1.10 *Compliance Officer;	X					Billy Quarles is the Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					
1.10.2 Program Integrity FWA Investigative/Review Staff;	X					
1.11 * Interagency Liaison;	X					
1.12 Legal Staff;	X					Healthy Blue's legal representative is Melanie Joseph, JD.
1.13 Board Certified Psychiatrist or Psychologist;	X					Jorge Hernandez-Chaple, MD is the board certified psychiatrist.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO processes provider claims in an accurate and timely fashion.	X					Healthy Blue's claims benchmark requires the organization to pay 98% of claims within 30 days and 99% of claims within 90 days. This benchmark exceeds the State's requirement and is reflected in the organization's measured average claim payment times.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Healthy Blue's systems are capable of accepting and generating Health Information Portability and Accountability Act (HIPAA)-compliant electronic transactions. It was specifically noted in the health plan's documentation that the organization uses industry standard formats for its electronic and paper claims.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Healthy Blue's business partner updates 834 files daily and uses the unique SCDHHS-assigned number from the enrollment files to identify enrollees. The organization noted that its systems use state-assigned member numbers and members are referenceable across multiple systems with the state-assigned numbers. Finally, duplicate records are checked during initial entry and again during adjudication.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Healthy Blue and its business partners use National Committee for Quality Assurance (NCQA)-certified software to generate Medicaid HEDIS and HEDIS-like reports. Reporting data is updated monthly and the health plan reviews the data to ensure reasonableness.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Healthy Blue requires Federal Information Processing Standard (FIPS) 140-2 approved encryption methods for data in transit, storage, and at rest. Additionally, the health plan requires full disk encryption for laptops and desktops as well as any mobile devices that store confidential data.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Healthy Blue has implemented policies and procedures to secure its systems, networks, and physical premises. Access to the health plan's system is granted on the principal of least privilege. Additionally, the health plan requires multifactor authentication for systems to be accessed remotely.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Healthy Blue's Disaster Recovery (DR) Plan is comprehensive and is tested on a scheduled basis. The most recent DR test involved recovering and testing failover to a secondary data center. The test was completed successfully with minimal issues. Discovered issues were documented and addressed during the exercise.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Healthy Blue by Blue Choice Health Plan of South Carolina Compliance Plan (Compliance Plan) outlines the process to prevent, detect, and respond to violations of ethical standards, contract requirements, and applicable federal regulations. The Compliance Plan is regularly

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reviewed and updated as needed. Written policies, procedures and standards of conduct are made available to employees at the time of employment and annually, thereafter.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The 2022 Compliance Overview and Our Values document, along with written policies, procedures, and standards, outline expectations of conduct and the organization's commitment to comply with all applicable Federal and State standards and regulations.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Officer is identified on the 2022 Healthy Blue Compliance Organizational Chart, the Healthy Blue Organizational Chart, and the Key Personnel List.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The 2022 Compliance Committee Charter describes the Healthy Blue Compliance Committee roles and responsibilities. The purpose of the committee is to provide a centralized mechanism for addressing compliance initiatives and risk management concerns.
2.5 Compliance training and education;						Continuing employee education and training about legal and ethical obligations under applicable laws, regulations, and policies, including federal health care program

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements, is an essential element of Healthy Blue's Compliance Plan.
2.6 Lines of communication;						Management maintains an open-door environment that encourages open communication with staff. Employees also may contact the Compliance Officer with questions or concerns. In the event a person wishes to remain anonymous, the Healthy Blue confidential Fraud Hotline is available 24 hours a day, 7 days a week, to report suspected cases of fraud, abuse, or other noncompliance, as explained in the Special Investigations Unit Antifraud Plan.
2.7 Enforcement and accessibility;						Healthy Blue maintains a "zero tolerance" policy regarding conduct that negatively impacts the operation, mission, or reputation of Healthy Blue. Any employee or contractor who knowingly or intentionally violates applicable laws or regulations is subject to discipline, up to and including termination of employment or contract. The standards established in the Compliance Plan are consistently enforced through disciplinary action.
2.8 Internal monitoring and auditing;						Monitoring and auditing are critical elements in Healthy Blue's Compliance Plan. Compliance-related elements are used to develop metrics for evaluating performance against regulatory standards.
2.9 Response to offenses and corrective action;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					Every complaint is entered into the case tracking system. Investigations may be transferred to a case. Internal referrals are issued based on findings, education, and discipline as appropriate.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy ING RX HOME 42001, Lock-In SC Medicaid, describes processes for identifying members who may be over-utilizing prescribers, medications, and pharmacies. This restriction program reduces inappropriate utilization, reduces costs, and improves quality of life through enhanced coordination of care.
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					The approach to privacy and confidentiality is addressed in Policy MCD-09, Privacy and Confidentiality. This policy outlines the responsibility of each Healthy Blue employee to safeguard member information. All areas are responsible for notifying the Compliance Department of any non-permitted disclosure or suspected disclosure. The Compliance Department reviews all disclosures to determine if the disclosure is a breach that requires further action.

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)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 overall credentialing process is addressed in the Healthy Blue Credentialing Program Plan. Related policies provide additional detailed information about credentialing and recredentialing processes and requirements. These policies include: •MCD – 04, Initial Credentialing •MCD – 05, Recredentialing •MCD – 06, Health Care Delivery Organizations - Credentialing/Recredentialing •MCD – 10, Credentialing Delegation Onsite discussion confirmed providers can appeal any denial of credentialing or recredentialing. However, there appear to be inconsistent information within Policy MCD—04, Initial Credentialing, pages 7-8, item 11. It states "Notification of a decision not to credential a practitioner is communicated by the Medical Director via certified mail within 60 days. No appeal process will be made available." Item 11 later states, "An appeal process within will only be made available in the instance of a decision not to credential a practitioner in the absence of additional explanatory documentation for affirmative responses to Health and History section of the application. No appeal process is available within 365 days of a determination not to credential a practitioner, based on careful

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review of additional explanatory documentation for affirmative responses to Health and History section of application." *Recommendation: Update Policy MCD-04 to clarify when/if providers may appeal decisions to deny credentialing and recredentialing determinations.*
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					The Credentialing Committee, chaired by the BlueChoice HealthPlan Chief Medical Officer, meets monthly and a quorum is established with the presence of three external committee members. Committee membership includes an array of external providers with specialties of internal medicine, pediatrics, pulmonology, obstetrics and gynecology, a nurse practitioner, and a chiropractor. Internal practitioners include a pediatrician and an ophthalmologist. The Provider Credentialing/Recredentialing Charter specifies attendance requirements for committee members. Onsite discussion confirmed one external provider was removed from the committee due to attendance issues and replaced by a provider specializing in family practice.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					No issues were identified in the sample of initial credentialing files reviewed.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					No issues were identified in the sample of recredentialing files reviewed.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Processes for taking action against providers are documented in Policy MCD-07, Professional Practitioner – Restriction, Suspension or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Termination. Healthy Blue's Credentialing Committee or Medical Director can restrict, suspend, or terminate a provider's network participation when issues of quality of care are identified. Network participation may also be restricted, suspended, or terminated when there are federal sanctions or if the provider fails to meet credentialing standards. Policy MCD-07 addresses provider notification, reporting to state agencies, the NPDB, state licensing boards, etc.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					No issues were identified in the sample of organizational provider initial credentialing and recredentialing files.
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					The health plan defines primary care physicians (PCPs) as family practitioners, pediatricians and internal medicine physicians contracted as PCPs. The geographic access standard for PCPs is defined in Policy MCD-11, Medicaid

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Access/Availability Standard, as one provider within 30 miles and 45 minutes for 95% of the population. The Healthy Blue Network Analysis Drive Distance – Summary, dated February 22, 2022, and the Driving Time Part 1, dated February 18, 2022, reflect use of appropriate time and distance parameters for providers classified as PCPs, and members have choice of at least 2 providers within the defined parameters.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					The geographic access standard for specialists is defined in Policy MCD-11, Medicaid Access/Availability Standard, as one specialist within 50 miles and 75 minutes for 95% of the population and 1 OB/GYN within 30 miles for 95% of the population. Policy MCD-11, Medicaid Access/Availability Standard, indicates the geographic access standard for hospitals is 1 hospital within 50 miles and 75 minutes for 95% of the population. The Healthy Blue Network Analysis Drive Distance – Summary, dated February 22, 2022, and the Driving Time Part 1, dated February 18, 2022, reflect use of appropriate time and distance parameters for specialists and hospitals. For the Status 1 providers, members have choice of at least 2 providers within the defined parameters.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Healthy Blue monitors the number and geographic distribution of PCPs by running Geo Access mapping at least annually. Healthy Blue also monitors member satisfaction survey results and member grievances to assess member access to providers. Healthy Blue submits bi-annual reports outlining network adequacy to SCDHHS.
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					As noted in the "Provider Network, Cultural Responsiveness" policy, Healthy Blue's Cultural and Linguistic Program is designed to ensure culturally competent and linguistically appropriate services. Healthy Blue uses several factors to assess the provider network. Key factors include member population and member language preferences. Additional activities undertaken to achieve the program's goals are detailed in the policy. Provider resources available on Healthy Blue's website include the "Caring for Diverse Populations" toolkit, Cultural Competency Training, and a link to the My Diverse Patients website. The Provider Manual includes a brief chapter on Cultural Competency and a link to the My Diverse Patients website.

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 Network Growth Report for MY 2021, dated March 10, 2022, indicates an increase of approximately 900 providers from January 2021 to December 2021.
2. The MCO maintains a provider directory that includes all requirements.	X					Healthy Blue offers a printed version of its Provider Directory as well as the "Find a Doctor" tool on the plan website. Elements that must be included in the online Provider Directory are found in Policy MCD-21, Provider Directory. The policy also lists elements that must be included in the printed Provider Directory; however, it does not include office hours and age groups, as required by the *SCDHHS Contract, Section 3.13.5.1.1*. Onsite discussion confirmed both the print version of the Provider Directory and the online provider search tool are updated at least weekly. *Recommendation: Revise Policy MCD-21, Provider Directory, to include office hours and age groups as required elements of the print version of the Provider Directory.*
3. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to		X				Policy MCD-11, Medicaid Access/Availability Standard, lists appointment access standards. The "Physician Office Accessibility Standards"

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
practitioners and that are consistent with contract requirements.						table on page 4 of the policy states "routine care appointments should be scheduled within four weeks of request." However, the last line of the table states, "Health Maintenance and Preventative Care –To meet criteria, appointments should be scheduled within 8 weeks." The Provider Manual, page 115 also lists the additional standard for Health Maintenance and Preventative Care. This finding was discussed during the onsite and staff were unable to describe the difference between routine care and health maintenance / preventive care. Staff also confirmed this is not a standard that is monitored. Also, the policy does not address the requirement from the *SCDHHS Contract, Section 6.2.2.3.5*, that "Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling Procedures." *Quality Improvement Plan: Revise Policy MCD-11 to remove the appointment standard for Health Maintenance and Preventative Care. Include information that walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					The Healthy Blue Provider File contained a population of 2,313 PCPs. To conduct the Telephone Provider Access Study, CCME selected a random sample of 170 PCPs. CCME chose only providers located in SC and documented as accepting new patients for the sample. CCME attempted to contact these providers to ask a series of questions regarding the access members have with the contracted providers. For the Telephonic Provider Access Study, calls were answered successfully 69% of the time. When compared to last year's rate of 59%, the increase in successful answer rate was not statistically significant (p = .052). For those not answered successfully (n=44 calls), 18 (41%) were unsuccessful because the provider was not at the office or phone number listed.
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					Information about initial provider orientation is found in Policy MCD-01, Education of Contracting Providers. Providers are educated about Healthy Blue's MCO Program and Medicaid regulations at initial contracting. Initial orientation and ongoing education are provided during in-person and virtual sessions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Healthy Blue Workshop New Professional Provider Training 2021 document provides a comprehensive overview of the health plan. Providers may contact the health plan as needed.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Ongoing provider education provisions include educational/reference materials, website updates, and special mailings. Healthy Blue holds regional provider training sessions throughout the state at least annually.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Amerigroup adopts preventive health guidelines (PHGs) from nationally recognized source organizations. The corporate-level Clinical Practice Guidelines/Preventive Health Guidelines (CPG/PHG) Workgroup reviews recommended changes annually or whenever pertinent or new evidence is available. This review is followed by review and approval by regulatory and legal staff prior to the proposed recommendations being presented to the Clinical Quality Improvement Committee (CQIC) for approval and adoption.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Clinical practice guidelines (CPGs) that are relevant to health plan membership and that provide practitioners with evidence-based resources for health care delivery are adopted from nationally-recognized organizations. Behavioral health guidelines are developed internally and incorporate information from nationally recognized source organizations. The CPGs are updated at least annually and when there are changes to national guidelines. The guidelines are adopted by the CQIC.
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					Information about the CPGs is included in the Provider Manual and the guidelines are posted on the website. The 2021 Clinical Practice Guidelines matrix on the Healthy Blue website lists and includes links to the adopted CPGs. Printed copies are available upon request. Provider compliance with the CPGs is assessed via medical record audits and monitoring utilization data and HEDIS gap-in-care data.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Policy SC_QMXX_080, Monitoring Continuity and Coordination of Medical Care, states coordination and continuity of care is promoted. As noted in the policy, PCPs are responsible for coordinating member care among medical and behavioral health providers. Member medical records should

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reflect documentation of communication between the treating practitioners and across sites of care. Continuity and coordination of care is monitored and opportunities to improve coordination of care are identified and actions are implemented.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy SC_QMXX_105, Medical Record Compliance Audit For Documentation Standards, describes processes for assessing PCP compliance with medical record documentation standards. The documentation standards are detailed on the Medical Record Compliance Audit tool attached to the policy. Healthy Blue conducts annual Medical Record Compliance Audits for a sample of PCPs. Policy SC_QMXX_105 defines the scoring expectation for medical record audits as well as processes followed for substandard performance.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The 2021 Medical Record Compliance Audit was reported to the CQIC in April 2022. Of 104 records across a sample of 41 providers, 96.9% of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the providers passed the audit. Two providers did not meet the minimum score of 90%. For the two providers who did not pass, a letter was mailed explaining the deficiencies and a meeting was scheduled to review the findings. A second audit will be conducted within 6 months.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy SC_ QMXX_104, Member Rights and Responsibilities, the Member Handbook, and the website, clearly list member rights and responsibilities.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					The Benefits Quick Reference Guide describes covered services with limits of coverage and exclusions. Additionally, benefit information is noted on the website and members can contact the Customer Care Center for additional information. Policy SC_COXX_126, Annual Notification to Members, describes Healthy Blue's approach to notifying members of their covered services and benefits.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services are clearly listed in the Member Handbook and on the website that require prior authorization with instructions for available assistance. Prior approval is not required for family planning services, emergency visits, or behavioral health services.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Members are instructed to call 911 or go to the nearest hospital if they are experiencing what they perceive to be an emergency. Members are informed that in addition to their PCP, the Nurse Advice Line is available 24 hours a day, seven days a week.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						Both the Member Handbook in the Benefits Quick Reference Guide and website contain information on Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services.
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						Information is available in the Member Handbook that defines the term "advanced directive" and outlines steps on how to obtain an advanced directive.
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC_UMXX_125, Termination of Membership (Disenrollment) - Coordination of Care, provides information and steps needed to disenroll.
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 describes Healthy Blue's Disease Management (DM) Program, which helps members receive health information to enhance quality of life.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Healthy Blue contracts with Center for the Study of Services (CSS), a certified Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey vendor to conduct the adult and child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					The QI Evaluation displays the analysis of data and outlines action steps taken to achieve higher member satisfaction scores.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The 2022 QIC Work Plan indicates that the CQIC presents results and initiates Quality Improvement Plans to address problematic measures.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The December 2021 CAHPS Survey Provider Bulletin provides the results of the CAHPS Surveys to providers.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The SQIC Q3 2021 Presentation provides the CAHPS Outcome report to the CQIC.
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_GAXX 015, Grievance and Appeals for Members, outlines procedures for the receipt and prompt resolution of member grievances.
1.1 The definition of a grievance and who may file a grievance;	X					A grievance is defined as “An expression of dissatisfaction about any matter other than an adverse benefit determination.”

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Procedures for filing and handling a grievance;	X					Members may file a grievance verbally or in writing at any time or may authorize a relative, a representative, or a health care practitioner or provider to represent them.
1.3 Timeliness guidelines for resolution of a grievance;	X					
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					All clinical grievances are assigned to grievance and appeal clinical associates for review and appropriate action. The medical directors reviewing clinical grievances are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease.
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Healthy Blue submits a quarterly grievance log to SCDHHS as required. A copy of the grievance log is retained for a minimum of 10 years in accordance with *S.C. Code Ann. § 38-33-110 (2) (a) (Supp. 2002, as amended)* and the *SCDHHS Contract*.
2. The MCO applies grievance policies and procedures as formulated.		X				Policy SC_GAXX 015, Grievance and Appeals for Members, indicates that a written acknowledgement of the member's grievance is sent within 5 calendar days of receipt of the grievance. CCME reviewed a sample of grievance files and found that three of the files did not meet Healthy Blue's Policy SC_GAXX-015 for sending a written acknowledgement within five calendar days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Conduct an internal audit of files to ascertain compliance with Healthy Blue's grievance policy. Address any deficiencies with staff to determine interventions needed to improve performance.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					Grievances are managed per the policies of Healthy Blue and the Grievances and Appeals Department.

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)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					Healthy Blue submitted the 2022 Medicaid Quality Management Program Description for review. This program description is updated annually and submitted to the Clinical Quality Improvement Committee for approval. The program description describes the quality improvement program's scope, goals, objectives, structure, and functions for the plan. Healthy Blue provides information to members and providers about the QI Program via the Provider Manual, Member Handbook and on the website. The website contained information regarding the 2021 HEDIS and CAHPS rates, projects underway, goals for 2022, and how a member or provider can obtain more information.
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					Utilization trend reports are analyzed for patterns of over and under-utilization annually. Results are reported to the Service Quality Improvement Committee and the Clinical Quality Improvement Committee.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Healthy Blue develops a Work Plan annually. CCME requested and received the 2021 and 2022 Work Plans. The Work Plans included the activities for the year, objectives, frequency, responsible party, completion date and updates or comments. The tab labeled Contracts and Dashboards was blank on the 2021 Work Plan. It did not include the benchmark/goal nor did it record quarterly updates. Also, the Contract and Dashboard tab was missing in the 2022 Work Plan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Healthy Blue staff mentioned changes were made to the Work Plan based on NCQA changes and the Contract and Dashboard tab was removed in the 2022 Work Plan.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Managed Care Oversight Committee provides oversight of quality across all lines of business for Healthy Blue. This committee reports directly to the Board of Directors. The development, implementation, monitoring, and evaluation of the QI program is delegated to the CQIC. The CQIC provides oversight for Healthy Blue's efforts to measure, manage, and improve the quality of care and services delivered to members, as well as evaluate the effectiveness of the QI Program. Primary responsibilities are included in the committee charter.
2. The composition of the QI Committee reflects the membership required by the contract.	X					CQIC membership is composed of both health plan staff and external contracting providers. Meetings are co-chaired by the Healthy Blue Medical Director and the Assistant Vice President, Medicaid. Voting members include seven actively participating providers who specialize in family medicine, OB/GYN, pediatrics, emergency medicine, and psychiatry. A meeting quorum is established with the attendance of three contracting providers. The July 2021 meeting minutes reflected a lack of a quorum of voting members present. The minutes indicated documents requiring approval would be sent to members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						electronically. The minutes further specified the documents were sent electronically on July 27th and were approved as of July 30th.
3. The QI Committee meets at regular quarterly intervals.	X					The CQIC meets at a minimum of four times per year. In 2021, the committee met in January, April, July, and October.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
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					Healthy Blue produces HEDIS rates using software from a NCQA-certified measure vendor. The performance measure validation found that Healthy Blue was "fully compliant" with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b).* The comparison from the previous to the current year revealed an over 10% increase in Pharmacotherapy Management of COPD Exacerbation (pce)- Systemic Corticosteroid, Follow-Up After Hospitalization for Mental Illness (fuh) of 7 day follow up in the 6 to 17 year olds from 40.09% to 52.09%, Pharmacotherapy for Opioid Use Disorder (pod) for 16 – 64 year olds and total and Initiation and Engagement of AOD Dependence Treatment (iet), specifically the Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years and Opioid abuse or dependence:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Engagement of AOD Treatment: Total. One measure had a substantial decline of more than 10%, and that was Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm) cholesterol testing for 12 to 17 year olds.
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					Healthy Blue submitted two performance improvement project (PIPs) for validation. The Comprehensive Diabetes Care PIP and a new PIP, CAHPS – Child with Chronic Conditions Customer Service PIP.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					The PIPs met the validation requirements and received scores within the "High Confidence Range." The interventions for the CAHPS – Child with Chronic Conditions Customer Service PIP do not align with the indicator regarding improving customer service. *Recommendation: Include interventions in the CAHPS – Child with Chronic Conditions Customer Service PIP that directly address improving customer service.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Providers are informed in the Provider Manual and in the provider educational material regarding their active participation in the QI program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Healthy Blue evaluates the overall effectiveness of the QI Program and reports this assessment to the CQIC. The 2020 Medicaid Quality Management Program Evaluation was provided. The program evaluation included the results of all completed activities conducted in 2020. Results of the evaluation are used to develop recommendations for improvement and priorities for the upcoming year. There were no issues identified with the program evaluation.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					Healthy Blue provided the 2022 Utilization Management Program Description, titled Utilization Management (UM) Program Description Template 2022 for review. The UM Program Description and several policies and documents guide staff in the implementation of UM functions. The UM Program Description was last reviewed and approved in April 2022.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					

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					
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description describes the Chief Medical Officer's (CMO) role and responsibilities. For Healthy Blue, Dr. Imtiaz Khan oversees all aspects of the UM Program. The Behavioral Health Medical Director provides oversight and expertise for behavioral health services.
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					Healthy Blue evaluates the UM Program annually. Results and recommendations are presented to the Quality Improvement Committees as applicable. Healthy Blue provided the UM Program Evaluation covering measurement year 2021 as evidence of this evaluation.
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*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Healthy Blue's medical necessity screening criteria are based upon nationally recognized standards of UM practice and are reviewed and approved annually by the Medical Policy and Technology Assessment Committee (MPTAC) and the CQIC. Policy SC_UMXX_118, Utilization Management Decision and Screening Criteria, and Policy and Procedure Clinical Criteria for Utilization Management Decisions – Core Process, discuss the process for applying the criteria and the dissemination of the criteria to members and providers as requested. UM staff receive updates regarding interpretation and application of the criteria guidelines. The health plan provides quarterly updates via email, departmental meetings, and as changes to UM, decision criteria guidelines and policies and procedures occur.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM files reflect use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					Requests for medical services that do not meet the medical necessity criteria or that require further medical review are routed to a Peer Clinical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Reviewer. Only licensed physicians are able to deny a medical service or treatment.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					The UM Program Description and policies SC_UMXX_120, Nurse Inter-Rater, and SC UMXX 078, Physician Inter-Rater Reliability Assessment, describe the process Healthy Blue uses to evaluate the quality and consistency of clinical decisions among reviewers. Nurse reviewers, medical directors, and physician reviewers who apply screening and decision criteria are audited periodically, and at least annually. Results are reported to the SQIC and CQIC. The benchmark or goal is 90%. Scores below 90% require documented re-education, re-testing, and auditing. Results of the 2021 IRR were reported in the UM Program Evaluation, which also identified barriers and opportunities for improvement.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.		X				The Pharmacy Program Description explains that IngenioRx is the pharmacy benefit manager and is responsible for implementing all pharmaceutical services for Healthy Blue, including prior authorizations and pharmacy network management activities. Healthy Blue's website contains information regarding covered prescriptions including a copy of the Preferred Drug List (PDL) and any changes made to the PDL. The PDL change

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						document found on the website included the effective date, the product name, and the changes made. It was not clear when the changes were posted to the website. Page 10 of the Pharmacy Program Description indicates the PDL and formulary documents are updated quarterly. Changes are posted to the website upon their effective date. However, the *SCDHHS Contract* requires the change be published on the website at least 30 days prior to implementation. *Quality Improvement Plan: Update the PDL change document posted on the website and include the date the change document was posted. Also, update the Pharmacy Program Description to indicate that changes are published on the website at least 30 days prior to implementation as required by the SCDHHS Contract, Section 4.2.21.2.1 and 4.2.21.3.*
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					Policies GBD-HCM-005, Emergency Services - Core Process and GBD-UM-006, Coverage for Post Stabilization Care Services, define Healthy Blue's process for covering emergency and post stabilization service.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
8. Utilization management standards/criteria are available to providers.	X					Members and providers are notified that criteria are available upon request by contacting the UM Department or available on the Healthy Blue website.
9. Utilization management decisions are made by appropriately trained reviewers.	X					
10. Initial utilization decisions are made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Review of denial files revealed adverse benefit determinations are timely and notices to the requesting provider and member are communicated according to processes described in Policy SC_UMXX_117, Decision and Notification Timeframes.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC_GAXX_051, Member Appeal Process-SC, describes how appeals are submitted and processed. Appeal information is provided in the Member Handbook, Provider Manual, and on the website. The website also includes forms for members or providers to file the appeal.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				CCME's review of appeal files concluded that Healthy Blue's staff did not consistently process standard and expedited appeal requests according to guidelines in Policy SC_GAXX_051, Member Appeal Process. The following are issued identified with the appeal files: •Healthy Blue's Policy SC_GAXX_051, Member Appeal Process, indicates the member or authorized representative is mailed a copy of the case file, within 10 calendar days of receipt of the appeal. There were nine files where the case file was not sent within the 10-day timeframe or was not sent at all. This was an issue identified during the 2021 EQR. •Three files required the member to submit the appeal request in writing after requesting the appeal orally, even though this is no longer a requirement. •The physician who made the appeal decision for three files was not the same or similar specialty as the requesting provider. *Quality Improvement Plan: Conduct a root cause analysis to identify barriers for not processing appeals according to the health plan's policy,*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						SCDHHS Contract, and federal regulations. Implement interventions to address the barriers.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					The Complex Case Management 2021-2022 Program Description (CM Program Description) includes the program's mission, vision, goals and objectives, lines of responsibility and accountability within the program, staffing credentials, and training requirements. The program description addresses member identification, assessment, care plan development, and ongoing monitoring activities. The 2022 Population Health Program Description describes activities to target members with specific health conditions using a "gap-in-care" service model to develop care plans. Related processes and procedures provide staff with guidance for conducting CM activities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from care management.	X					As noted in Policy SC_CAXX_007, Care Management Targeting /Case Finding, identification of members who may benefit from CM services is achieved through methods that include internal and external referrals, predictive modeling, data mining, and health risk assessments. Certain diagnosis codes and/or procedure codes may trigger a CM referral. Onsite discussion confirmed all newly enrolled members receive a printed copy of the Health Risk Screening to complete and return. Plan staff reported good response rates to the mailed screening forms and that more members respond to the mailed forms than responded to verbal outreach attempts in the past.
3. The MCO provides care management activities based on the member's risk stratification.	X					The 2022 Population Health Program Description, page 14, indicates all members are stratified into 5 levels using predictive modeling. For members with the most complex needs, Healthy Blue applies a second predictive model that ranks members on their likelihood of an inpatient admission within 60 days using diagnoses, demographics, recent admissions, specialist visits, pharmacy, and emergency room utilization. The stratification levels rank members from lowest risk (Group 0) to highest risk (Group 4) so that appropriate CM activities and interventions are

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						included in the plan of care and management of the member.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Processes and requirements for managing transitions of care are addressed in the following: •Policy SC_PMXX_020, Prescription Transition Period – SC. •Policy SC_CAXX_110, Case Management Transition and Continuity of Care: Current Provider Terminates with Plan. •Policy SC_CAXX_097, Transition to Other Care When Benefits End. •Policy SC_CAXX_079, Case Management/New Enrollment: Transition Assistance-Continuity of Care.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					
6. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					According to the Complex Case Management 2021-2022 Program Description, Healthy Blue conducts an annual CM Program evaluation to assess the efficiency and effectiveness of the program. The evaluation monitors year over year performance and outcomes, including identification and engagement,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						participation rates, program satisfaction, and results of program clinical measures. The evaluation informs process improvement activities to address any identified inefficiencies, or problem areas. The Healthy Blue Case Management Program Evaluation for 2021 (dated 3/17/2022) includes program highlights, accomplishments, and opportunities for 2022. Member satisfaction with the Complex Case Management Program is evaluated through a vendor-conducted telephonic survey process. Survey results are reviewed quarterly to identify trends and opportunities for improvement.
7. Care management and coordination activities are conducted as required.	X					The review of a sample of CM files confirmed staff adhere to established policies and processes when conducting CM activities. The files reflected appropriate assessments, care plan development, and ongoing monitoring and assessment of progress. Multiple attempts are made to contact members when initial attempts are unsuccessful, and appropriate case closure when continued attempts to contact the member are unsuccessful.
V E. Evaluation of Over/ Underutilization						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					A policy is in place to ensure that Healthy Blue monitors and analyzes relevant data to detect and correct patterns of potential or actual inappropriate under or over utilization which may impact health care services, coordination of care, and appropriate use of services and resources. Healthy Blue analyzed and monitored data, and offered recommendations based on findings for the several services in regard to utilization in the committee meetings and in the 2020 Under and Over Utilization report.
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					The HEDIS MY2020 rate for ER visits per 1000 member months decreased from 2019 to 2020 by 18.68 percentage points and is below the NCQA's Quality Compass National thresholds of 50%. The utilization rate of 6.05 for General Hospital/Acute Care Discharges/1000 member months was within the parameters for NCQA National under & over utilization threshold limits of 5.64 - 9.54 for the Medicaid population, with a decrease of 1.08 Discharges/1000 member months from MY 2019 to MY 2020.

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					The Delegate/Vendor Oversight and Management Program policy and procedure document describes processes for delegation of health plan activities and oversight of delegated entities. The Delegation Operations Committee oversees delegation processes. Potential delegates are subjected to pre-delegation assessment to determine capabilities for conducting functions in compliance with all requirements and established delegates are subjected to annual oversight and ongoing monitoring. Pre-delegation assessments and annual assessments are conducted using standardized audit tools that are specific to functional areas. Pharmacy benefit management is delegated to IngenioRx and CVS/Caremark. Credentialing activities are delegated to: •AnMed Health •BIO-IQ •Bon Secours St. Francis •Atrium Health (CPN)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Lexington Medical Center (LMC) •Matrix Health •MUSC •Online Care Network II •Preferred Care of Aiken •Prisma Health Upstate •Prisma Health Midlands •Regional Health Plus / SRHS •Roper St. Francis •SC DMH •Signify Health •Vision Service Plan (VSP)
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				Documentation was submitted for all delegated entities showing annual and/or pre-delegation assessment conducted in the last year. The documentation shows recommendations and corrective actions were implemented with the delegates when appropriate. For credentialing delegates, the file review worksheets do not provide evidence that the delegates are assessed for compliance with the initial credentialing processing timeframe or for ensuring applicable providers have admitting privileges.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure credentialing and recredentialing delegates are monitored for compliance with initial credentialing timeframe requirements and for ensuring applicable providers have admitting privileges or an admitting arrangement. These elements should be documented in the MCO Credentialing File Review Workbook used to assess credentialing delegates.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						As noted in Policy SC_PCXX_006, Preventive Health Guidelines (PHGs) - Review, Adoption, Distribution and Performance Monitoring, Healthy Blue monitors providers for compliance with preventive health guidelines through Medical Record Compliance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Audits and HEDIS performance gap-in-care data. Policy SC_PCXX_009, Pediatric Preventive Services/Provision of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services, states quarterly Gaps in Care reports are generated and disseminated to providers by Provider Network Services and/or Quality Management staff.
1.1 administering required immunizations;	X					
1.2 performing EPSDTs/Well Care.	X					
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			The current EQR revealed that a deficiency identified during the 2021 EQR was not corrected. The previously identified issue was related to not consistently following guidelines in Policy SC_GAXX_051, Member Appeal Process, for sending appeal case files to members within 10 calendar days. The current EQR revealed nine files in which the case file was not sent to the member within the 10-day timeframe referenced in Policy SC_GAXX_051, Member Appeal Process. *Quality Improvement Plan: Implement Quality Improvement Plans from the EQR to address all identified deficiencies.*