CCME

2019 External Quality Review

ABSOLUTE TOTAL CARE

Submitted: March 26, 2020

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 2019 *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 Absolute Total Care (ATC) since the 2018 Annual Review.

The goals of the review are to:

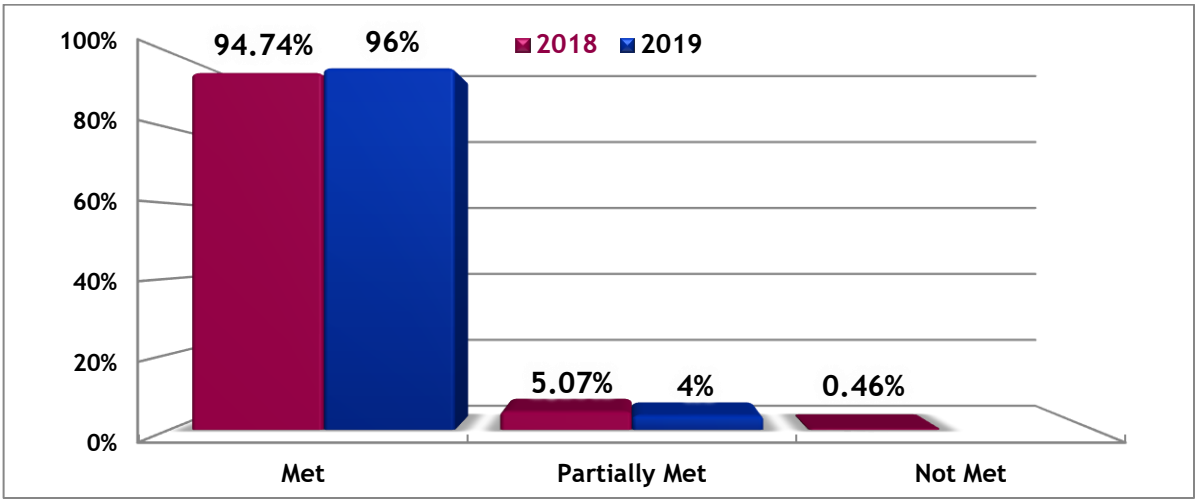
- Determine if ATC is following service delivery as mandated in the MCO contract with SCDHHS
- Evaluate the status of deficiencies identified during the ATC Annual Review and any ongoing quality improvements taken to remedy those deficiencies
- Provide feedback for potential areas of further improvement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

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

Overall Findings

The 2019 annual EQR shows that ATC has achieved a "Met" score for 96% of the standards reviewed. As the following chart indicates, 4% of the standards were scored as "Partially Met," and there were no standards scored as "Not Met." The chart that follows provides a comparison of ATC's current review results to the 2018 review results.

Figure 1: Annual EQR Comparative Results



Percents may not total 100% due to rounding.

Administration:

Adequate staffing is in place to ensure health care products and services required by the State of South Carolina are provided to members. Although ATC's organizational chart reflects staffing vacancies, onsite discussion confirmed several vacant positions have been filed and the remainder have been closed or placed on hold. ATC recently filled the Vice President of Medical Management position which was previously filled on an interim basis by the Senior Vice President of Quality Improvement.

Information Systems Capabilities Assessment documentation demonstrates ATC's personnel and systems have the capabilities to perform the Medicaid processing required by SCDHHS. Policies indicate data and resources are managed in a HIPAA compliant manner. To ensure capabilities extend beyond policies and procedures, ATC commissions regular system audits that validate access controls and successfully tests systems and recovery capabilities. ATC reported 98.6% of claims are payed within 30 days. This exceeds contractual requirements and is only 0.4% away from meeting the 90-day claims payment requirement.

Processes for detecting and preventing fraud, waste, and abuse are documented in ATC's *Compliance and Ethics Program Description 2019-2020*, the *Fraud, Waste and Abuse Plan*, and in related policies. The *Business Ethics and Code of Conduct* and *Employee Handbook* describe appropriate, ethical standards of business conduct. Mandatory compliance training for staff is conducted upon hire, annually, and as needed. In addition to Compliance training, various avenues are employed to communicate information about

compliance and fraud, waste, and abuse to staff, subcontractors, members of the Board of Directors, and others.

Provider Services:

The Provider Services review includes credentialing and recredentialing, network adequacy, accessibility, provider education, clinical practice guidelines, and continuity of care.

ATC has policies and procedures in place that outline the processes used for credentialing and recredentialing, and all requirements are included. ATC's Credentialing Committee, a standing subcommittee of the Quality Improvement Committee, is responsible for oversight and operating authority of the Credentialing Program. The Chief Medical Director chairs the Credentialing Committee. Other voting members include four network providers whose specialties include pediatrics, surgery, and psychiatry. A review of a sample of meeting minutes showed the committee met monthly and a quorum of voting members was present for each meeting.

CCME reviewed a sample of credentialing and recredentialing files and found that none of the practitioner credentialing files contained the date the SCDHHS Terminated for Cause List was queried. Copies of the Clinical Laboratory Improvement Amendment certificates were not found in several credentialing and recredentialing files. Other issues included the date of the Credentialing Committee's decision was not documented, evidence the SCDHHS Excluded Provider List query was missing, and a copy of the facility's license was not included.

ATC routinely monitors network adequacy using the required geographic access standards for PCPs, specialty providers, and hospitals. The geographic access standard for general practitioners was not met, but efforts are ongoing to recruit additional general practitioners to improve access in the affected counties. CCME could not identify the percentage of members with access to Rehabilitative Behavioral Health providers or Audiology Therapy providers in ATC's documentation. This information was requested from ATC during the onsite visit but was not provided.

Appointment access is monitored annually for PCPs and specialty referrals. CCME noted most of ATC's goals for appointment access for PCPs and specialty referrals are set at 90% and that on the most recent evaluation, goals were exceeded for three of four standards for PCPs and one of two standards for specialty referrals. CCME encourages ATC to consider increasing the goals for appointment access for PCPs and specialty providers.

ATC assesses members' cultural, ethnic, racial, and linguistic needs annually and makes adjustments to the provider network as necessary based on results of this assessment. Information about cultural competency is distributed to network providers through the

Provider Manual and on ATC's website. During the credentialing process, ATC ensures providers have completed cultural competency training. Training and toolkits to assist PCPs in developing culturally-competent and culturally-proficient practices are provided as needed.

ATC ensures Provider Relations staff conducts orientation and trainings for new providers within 30 calendar days of joining the network. Ongoing trainings and education for providers and office staff are appropriately provided via scheduled in-services, faxes, mailings, or in provider newsletters.

As part of the Annual EQR process for ATC, CCME conducted a provider access study focused on primary care providers. From ATC's list of current providers, a sample of 289 providers was randomly selected for the access study. Attempts were made to contact these providers to ask a series of questions regarding access that members have with contracted providers. The calls were successfully answered 71% of the time (172 of 243) when omitting calls answered by personal or general voicemail messaging services. This represents a statistically significant increase in successful calls when compared to last year's results of 60%. *Table 1: Telephonic Access Study Answer Rate Comparison* illustrates the results for successful answer rates for the 2018 and 2019.

Table 1: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2018 Review	278	60%	.0173
2019 Review	289	71%	

Of the 172 successfully answered calls, 95 providers (91%) indicated they accept ATC and 68 providers (75%) indicated they accept new patients. Regarding a screening process for new patients, 28 providers (58%) indicated they have prescreening requirements. Of the 28 providers with prescreening requirements, 23 (82%) require an application and a medical record review, and five (18%) require another form of prescreen such as ID, Insurance Card, and other information.

Member Services:

ATC has policies and procedures that define and describe member rights and responsibilities, as well as methods of notifying members of their rights and responsibilities. New members receive a *Welcome Packet* and Member Handbook with instructions for contacting Member Services, selecting a primary care provider (PCP) and initiating services. However, there is no documentation that members are notified of

their right to request a copy of the Provider Directory annually. All members have access to information and resources in the Member Handbook, Provider Manual, on the website, and in member newsletters that can help them utilize their benefits. Onsite discussion revealed ATC use 12-point font size in regular print and 18-point font size in large print member materials. However, documentation of each font size is in two separate policies, which can present a barrier for staff in meeting the requirement for printed materials. Additionally, ATC provides a list of preventive health guidelines and encourages members to obtain recommended preventive services.

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys continues to be conducted annually via a third-party vendor. The 2019 survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.

Processes for grievance handling and resolution are documented throughout policies, the Member Handbook, the Provider Manual, and on ATC's website. Onsite discussion confirmed that expedited grievance processing is strictly an internal process followed when a need for expedited processing is identified by ATC staff; however, the Member Handbook and Provider Manual indicate members and authorized representatives can request clinically-urgent grievance processing. Grievance files reviewed reflect ATC staff follow appropriate processes for receiving and responding to grievances. Acknowledgements and resolutions were timely, and appropriate internal referrals were made for potential quality of care issues. One grievance file contained incomplete information in the resolution notice provided to the member.

Quality Improvement:

ATC's Quality Improvement (QI) Program operates under a plan of continuous improvement. The *2019 Quality Assessment and Performance Improvement Program Description Medicaid* describes the program's structure, accountabilities, scope, goals and available resources. Annually, ATC develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2018 and 2019 QI Work Plans. Both work plans were complete and addressed the requirements.

ATC's Quality Improvement Committee (QIC) provides oversight and direction in assessing the appropriateness of care and service delivery. ATC's Medical Director chairs the QIC and members include network practitioners specializing in pediatrics, OB/GYN, family medicine, internal medicine, and behavioral health. Other members include senior management and internal department staff.

ATC evaluated the QI Program and summarized the results of this evaluation in the *Quality Assessment and Performance Improvement Program Evaluation Medicaid – 2018*.

Most of the program's objectives were met and areas not meeting the goals were analyzed and any interventions needed to improve performance identified.

Performance Measures and Performance Improvement Projects

The performance measures and performance improvement projects met the CMS validation requirements. *Table 2: HEDIS Measures with Substantial Changes in Rates* highlights the Healthcare Effectiveness Data Information Set (HEDIS®) measures with substantial increases or decreases in rate from 2018 to 2019. The comparison from the previous to the current year revealed a strong increase (>10%) in a few rates, including Systemic Corticosteroids and Persistence of Beta Blocker Treatment for those managing COPD, 80% Statin Adherence for female Cardiovascular Disease patients ages 40-75 years old, and overall 80% Statin Adherence. The measures that decreased substantially (>10%) were Initiation and Engagement of AOD Dependence Treatment for those 18 and older and who have opioid dependence and the total opioid initiation rate. As well, Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics decreased substantially for 12-17 year olds.

Table 2: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	MEASURE YEAR 2018	MEASURE YEAR 2019	CHANGE FROM 2018 TO 2019
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	55.56%	66.50%	10.94%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	51.35%	80.43%	29.08%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Statin Adherence 80% - 40-75 years (Female)	30.65%	50.66%	20.01%
Statin Adherence 80% - Total	36.81%	50.76%	13.95%
Substantial Decrease in Rate (>10% decrease)			
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Initiation of AOD Treatment: Total	51.12%	39.41%	-11.71%
Opioid abuse or dependence: Initiation of AOD Treatment 18+ Years	51.12%	39.50%	-11.62%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	63.27%	52.58%	-10.69%

ATC reported 12 quality clinical withhold measures for 2018. The Behavioral Health measures are considered Bonus Only for 2018. As per the *Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24 Percentile = 2 points; 25-49 Percentile = 3 points; 50-74 Percentile = 4 points; 75-90 Percentile = 5 points; >90 Percentile = 6 points). Points attained for each measure are multiplied by the individual measure's weight then summed to obtain quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 3: Quality Withhold Measures*. The Women's Health measure rates generated the highest index score, followed by Diabetes, and then Pediatric Preventive Care.

Table 3: Quality Withhold Measures

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.29%	90	6	4.45
HbA1c Control (>9)	42.34%	25	3	
Eye Exam (Retinal) Performed	57.91%	75	5	
Medical Attention for Nephropathy	90.79%	25	3	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	91.48%	90	6	5.10
Breast Cancer Screen	64.09%	75	5	
Cervical Cancer Screen	65.94%	75	5	
Chlamydia Screen in Women (Total)	59.65%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	68.37%	50	4	3.30
Well Child Visits in 3rd,4th,5th&6th Years of Life	63.75%	10	2	
Adolescent Well-Care Visits	55.96%	50	4	
Weight Assessment/Adolescents: BMI % Total	84.18%	75	5	
BEHAVIORAL HEALTH				

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
Follow-Up After Hospitalization for Mental Illness - 7 Days	27.43%	10	2	3.25
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation - Total	40.82%	25	3	
Follow Up for Children Prescribed ADHD Medication - Initiation	53.06%	75	5	
Continuation Phase-Antidepressant Medication Management - 180 Days (6 Months)	25.1%	<10	1	
Metabolic Monitoring for Children & Adolescents on Antipsychotics - Total	32.00%	50	4	
Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics - Total	52.52%	10	2	

ATC submitted two projects for validation. They included Postpartum Care and Provider Satisfaction. It was noted the rate decreased from baseline to follow-up for the Provider Satisfaction project. This was discussed during the onsite and ATC indicated a workgroup met to review and discuss the decrease in the rate. Additional training was provided to provider relations and call center staff to cover areas of provider concerns. ATC also implemented the Interpreta application that allows network providers to receive a real-time analysis of care gaps and will host semiannual regional meetings.

All performance improvement projects (PIPs) received a sore within the High Confidence Range. *Table 4: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

Table 4: Performance Improvement Project Validation Scores

PROJECT	2018 VALIDATION SCORE	2019 VALIDATION SCORE
Postpartum Care	98/98=100% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Provider Satisfaction	87/88=99% High Confidence in Reported Results	104/105=99% High Confidence in Reported Results

Utilization Management:

CCME's assessment of Utilization Management (UM) includes reviews of program descriptions, program evaluations, policies, Member Handbook, Provider Manual, a sample of approval, denial, appeal and case management files, and the website. Policies and procedures define how UM, medical necessity determinations, appeals, and CM services are operationalized and provided to members. The UM Program Description outlines the purpose, goals, objectives, and staff roles for physical and behavioral health.

CCME identified the following pharmacy related issues; the *Pharmacy Program Description* says ATC allows 30 days, instead of the 90 days, for new members to fill prescriptions that require prior authorization, the timeframe and communication method for Preferred Drug List (PDL) changes in Policy CC.PHAR.10, Preferred Drug List are inconsistent with ATC's processes, and the *Preferred Drug List Updates* is not in a prominent and easily accessible location on the website.

Overall, review of UM approval and denial files provided evidence that appropriate processes are followed; however, one file indicated additional information could have been requested prior to making an adverse benefit determination.

Requirements and processes for receiving, reviewing, and resolving member appeals are documented in ATC's policy, the Member Handbook, Provider Manual, and on ATC's website. Issues identified in documentation of appeals processes and requirements include incomplete information about requirements following the denial of a request for expedited appeal resolution, incomplete information about how members are supplied with the appeal case file and related documents, and discrepant information about requesting a State Fair Hearing. CCME's review of appeals files confirmed staff follow appropriate processes for receiving, reviewing, and resolving appeals.

The *Care Management (CM) Program Description* and policies appropriately document care management processes and service provided. Care Management files indicate care gaps are identified and addressed consistently with services provided for various risk levels. Service authorization requests are conducted by appropriate reviewers utilizing InterQual or other established criteria.

Delegation:

Pre-delegation and annual oversight monitoring were provided for all delegated entities. Deficiencies identified during the monitoring required the entity to complete a corrective action plan. The monitoring report and the oversight letter indicated follow-up for the corrective action items would not occur until the next annual monitoring. CCME recommends ATC follow-up on the deficiencies identified during pre-delegation and annual oversight monitoring before the next annual monitoring is conducted.

State Mandated Services:

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

Medical record reviews is one method used to monitor provider compliance with provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and required immunizations.

Table 5, Scoring Overview, provides an overview of the findings of the current annual review as compared to the findings of the 2018 review.

Table 5: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards
Administration						
2018	39	1	0	0	0	40
2019	40	0	0	0	0	40
Provider Services						
2018	72	6	0	0	0	78
2019	72	6	0	0	0	78
Member Services						
2018	32	1	0	0	0	33
2019	32	1	0	0	0	33
Quality Improvement						
2018	14	1	0	0	0	15
2019	14	0	0	0	0	14
Utilization						
2018	43	1	1	0	0	45
2019	44	1	0	0	0	45
Delegation						
2018	1	1	0	0	0	2
2019	2	0	0	0	0	2
State Mandated Services						
2018	4	0	0	0	0	4
2019	4	0	0	0	0	4

METHODOLOGY

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

On December 2, 2019, CCME sent notification to ATC that the annual EQR was being initiated (see Attachment 1). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow ATC to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from ATC on December 16, 2019 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 an onsite review conducted on February 26, 2020 and February 27, 2020 at ATC's office located in Columbia, SC. The onsite visit focused on areas not covered in the desk review or needing clarification. See Attachment 2 for a list of items requested for the onsite visit. Onsite activities included an entrance conference, interviews with ATC's administration and staff, and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in title 42 of the Code of Federal Regulations (CFR), part 438, and the contract requirements between ATC and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (Attachment 4).

A. Administration

Absolute Total Care (ATC) is the South Carolina subsidiary of Centene Corporation in St. Louis, Missouri. Absolute Total Care offers health plans for Medicaid, Medicare-Medicaid, Health Insurance Marketplace, and Medicare Advantage beneficiaries. John McClellan is ATC's President and Chief Executive Officer. He is responsible for the health plan's day-

to-day business activities and accountable to the Board of Directors and Centene. CCME's review of ATC's organizational chart and discussion during the onsite visit determined adequate staffing is in place to ensure health care products and services required by the State of South Carolina are provided to members. The organizational chart reflects staffing vacancies—these vacancies were discussed during the onsite visit and ATC reported several of the positions have been filled and the remainder placed on hold or closed. ATC recently filled the Vice President of Medical Management position which was previously filled on an interim basis by the Senior Vice President of Quality Improvement.

ATC uses the RSA Archer® system for policy storage and management. Policies are organized by department or functional area within the organization and are reviewed annually. On each policy, dates of review and revision are noted, and changes are documented on a revision log. Staff are informed monthly via email of new and revised policies.

Information Systems Capabilities Assessment documentation demonstrates ATC's personnel and systems have the capabilities to perform the Medicaid processing required by SCDHHS. Policies indicate data and resources are managed in a HIPAA-compliant manner. To ensure capabilities extend beyond policies and procedures, ATC commissions regular system audits that validate access controls and successfully tests systems and recovery capabilities. ATC reported 98.6% of claims are payed within 30 days. This exceeds contractual requirements and is only 0.4% away from meeting the 90-day claims payment requirement.

The *Compliance and Ethics Program Description 2019-2020* (Compliance Plan), *Fraud, Waste and Abuse Plan*, and related policies describe ATC's processes for detecting and preventing fraud, waste, and abuse. The *Business Ethics and Code of Conduct* and *Employee Handbook* describe appropriate, ethical standards of business conduct. ATC communicates information about compliance and fraud, waste, and abuse (FWA) to staff, subcontractors, members of the Board of Directors, and others through mandatory training programs or by disseminating publications that explain specific requirements. Mandatory compliance training is conducted for staff upon hire, annually, and as needed. Members of the Board of Directors must acknowledge receipt of, and agreement to comply with, the Code of Conduct. CCME encourages ATC to revise its Compliance Plan to reflect that new provider orientation includes training on identifying and reporting FWA. It currently states training on identifying and reporting FWA is provided to contracted providers "as necessary or upon request." However, Attachment A of Policy SC.PRVR.13, Provider Orientations indicates FWA training is a core element of provider orientation.

Figure 2, Administration Findings indicates 100% of the Administration standards are scored as "Met." *Table 6: Administration Comparative Data* illustrates standards with a change in score from the 2018 EQR.

Figure 2: Administration Findings

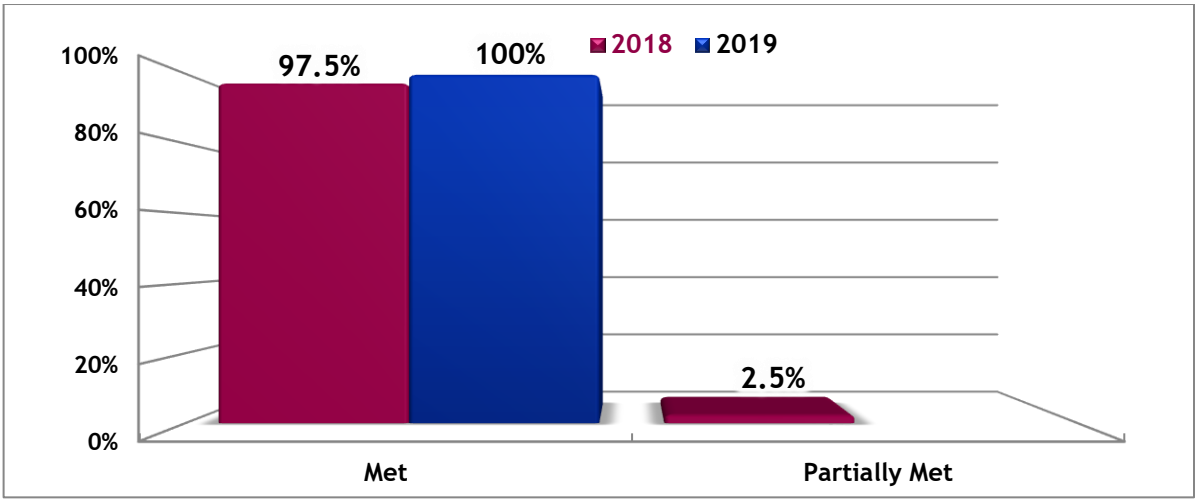


Table 6: Administration Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Compliance/ Program Integrity	The Compliance Plan and/or policies and procedures address requirements, including: Exclusion status monitoring	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- ATC's data management and processing systems function with multi-layered access controls which compensate for one another if there is a single control failure.

Weaknesses

- The Compliance Plan, page seven, states training on identifying and reporting FWA is provided to contracted providers as necessary or upon request. However, Attachment A of Policy SC.PRVR.13, Provider Orientations indicates FWA training is a core element of provider orientation.

Recommendations

- Revise page seven of the Compliance Plan to reflect that new provider orientation includes training on identifying and reporting FWA.

B. Provider Services

The Provider Services review includes credentialing and recredentialing, network adequacy, accessibility, provider education, clinical practice guidelines, and continuity of care.

Policy CC.CRED 01, Practitioner Credentialing & Recredentialing discusses the process ATC uses for credentialing and re-credentialing practitioners. The South Carolina specific requirements are addressed in footnotes throughout the document and in Attachment J. According to the policy, ATC will completely process credentialing applications within 60 days of receipt of a completed application. It was unclear how ATC monitors their timeliness for processing applications. The event tracking sheets provided with each credentialing and recredentialing file were incomplete. Staff indicated timeliness is monitored daily through their credentialing system.

CCME reviewed a sample of credentialing and recredentialing files. The issues identified in the files are outlined in the weaknesses section. ATC conducts a quality review of credentialing and recredentialing files in accordance with Policy CC.CRED.11, Credentialing Program Quality and Complaint Monitoring.

ATC's Credentialing Committee, a standing subcommittee of the Quality Improvement Committee, is responsible for oversight and operating authority of the Credentialing Program and has final authority to approve or disapprove provider applications. This committee meets monthly or no less than 10 times a year and reports to the Quality Improvement Committee quarterly. The Chief Medical Director chairs the Credentialing Committee. Other voting members include four network providers whose specialties include pediatrics, surgery, and psychiatry. A review of a sample of meeting minutes showed the committee met monthly and a quorum of voting members was present for each meeting.

ATC monitors network adequacy using appropriate geographic access standards for PCPs, specialty providers, and hospitals. ATC's network meets requirements for most provider types, but documentation indicates the geographic access standards for general practitioners is not met. Onsite discussion confirmed ATC has ongoing efforts in place to recruit additional general practitioners into its network to improve access in the affected counties. CCME could not identify in the submitted documentation the percentage of members with access to Rehabilitative Behavioral Health providers or Audiology Therapy providers. This information was requested from ATC during the onsite visit but was not provided.

In addition to monitoring geographic access standards for its network, ATC measures appointment access standards for PCPs and specialty referrals annually. It was noted in the *Practitioner Access Analysis 01/01/2018 to 12/30/2018* report that the goal for most

standards for PCPs and specialty referrals was set at 90%; however, three of four standards for PCPs and one of two standards for specialty referrals exceeded the 90% goal. CCME encourages ATC to consider increasing the goals for appointment access for PCPs and specialty providers.

ATC assesses members' cultural, ethnic, racial, and linguistic needs annually and makes adjustments to the provider network as necessary based in results of this assessment. Information about cultural competency is distributed to network providers through the Provider Manual and on ATC's website. During the credentialing process, ATC ensures providers have completed cultural competency training. Training and toolkits to assist PCPs in developing culturally competent and culturally proficient practices are provided as needed.

Provider Relations staff conducts orientation and trainings for new providers within 30 calendar days of active status. The *Provider Orientation* presentation is comprehensive and covers required topics. CCME identified several methods used for ongoing trainings and updates such as mailed letters, faxes, and Provider Newsletters posted on the provider website.

Provider Access and Availability Study

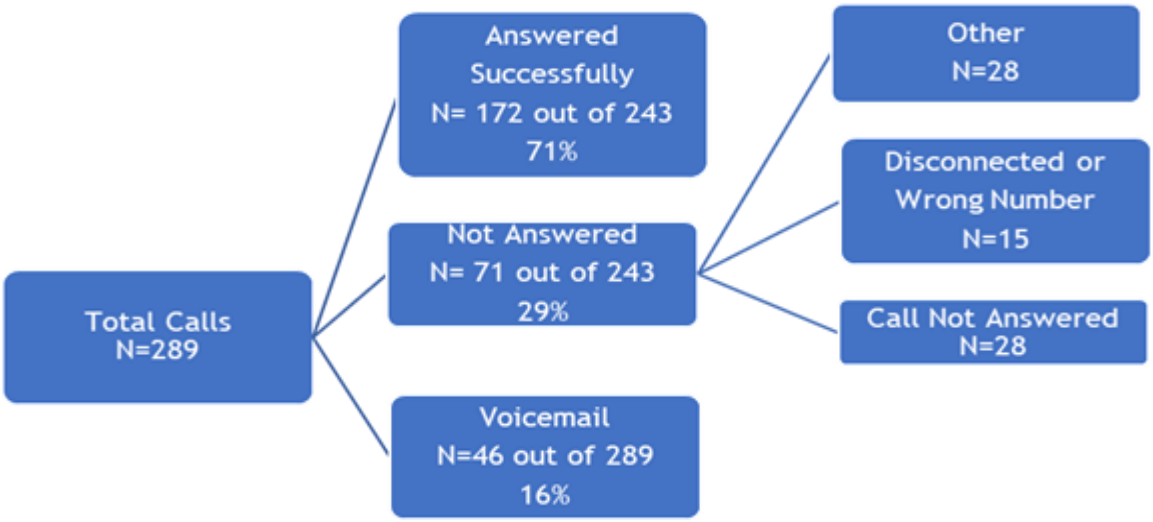
As part of the Annual EQR process for ATC, CCME conducted a provider access study focused on primary care providers. ATC gave CCME a list of current providers, from which a population of 3,196 unique PCPs was found. A sample of 289 providers was randomly selected from the total population for the access study. Attempts were made to contact these providers to ask a series of questions regarding access that members have with contracted providers. In reference to the results of the Telephonic Provider Access Study conducted by CCME, calls were successfully answered 71% of the time (172 of 243) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 60%, this year's study had a statistically-significant increase in successful calls at 71% (p=.0173). This year's study had an increase of 11% as shown in *Table 7: Telephonic Access Study Answer Rate Comparison*.

Table 7: Telephonic Access Study Answer Rate Comparison

	Sample Size	Answer Rate	Fisher's Exact p-value
2018 Review	278	60%	.0173
2019 Review	289	71%	

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

Figure 3: Telephonic Provider Access Study Results



For the 71 calls not answered successfully, 28 (39%) were because the call was not answered, and 15 (21%) were due to a wrong or disconnected phone number.

Of the successfully answered calls, 95 providers (91%) indicated they accept ATC and 68 providers (75%) indicated they accept new Medicaid patients.

Regarding a screening process for new patients, 28 providers (58%) indicated they do have prescreening requirements. Of the 28 providers with prescreening requirements, 23 (82%) require an application and a medical record review, and five (18%) require another form of prescreen such as ID, Insurance Card, and other information.

Figure 4: Provider Services Findings shows 92% of the standards in Provider Services received a "Met" score. *Table 8: Provider Services Comparative Data* highlights changes in scores from 2018 to 2019.

Figure 4: Provider Services Findings

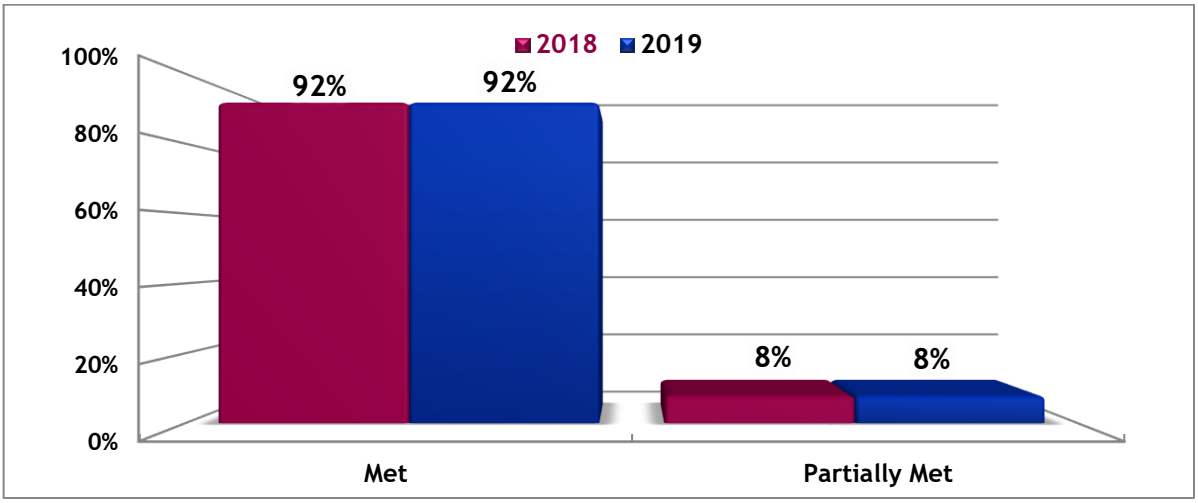


Table 8: Provider Services Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Met
	Credentialing: Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Partially Met
	Recredentialing: Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Partially Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Partially Met	Met
Primary and Secondary Preventive Health Guidelines	The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Partially Met	Met

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Adequacy of the Provider Network	Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- The Telephonic Provider Access Study success rate increased 11% from the 2018 study results. This is the third consecutive year an increase was noted.

Weaknesses

- None of the practitioner credentialing files (16) contained the date the SCDHHS Terminated for Cause List was queried.
- Four credentialing files and seven recredentialing files did not contain copies of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider's application indicated laboratory services were provided at locations where they currently practice.
- Seven recredentialing files did not contain the date of the Credentialing Committee's decision.
- Three recredentialing files did not show evidence the SCDHHS Excluded Provider List was queried.
- Issues identified in the organizational provider credentialing files included:
  - One file did not contain a copy of the facilities CMS certification. The CMS certification provided was for a different facility.
  - A copy of the facilities license was not provided for two facility files.
  - The SCDHHS Excluded Provider List query for one facility was more than a year old.
  - The date of verification for one facility's NPI number was missing.
  - The ownership disclosure form for one facility was not dated.
- Discrepancies in medical record documentation requirements were noted in the Medical Record Documentation Audit Tool (Attachment A of Policy SC.QI.13) and the Medical Record Documentation Standards document found on ATC's website.

- GEO Access Reports provided by ATC did not include Rehabilitative Behavioral Health providers and Audiology Therapy providers. This information was requested from ATC during the onsite but was not provided.
- ATC's *Practitioner Access Analysis 01/01/2018 to 12/30/2018* report indicates the goal for most standards for PCP and specialty referral access and availability standards was set at 90%. Three of four standards for PCPs and one of two standards for specialty referrals exceeded the goal.

Quality Improvement Plans

- Ensure credentialing files contain proof the SCDHHS Terminated for Cause List was queried.
- A copy of the CLIA Certificate or primary source verification of the CLIA Certificate number must be included in the credentialing and recredentialing files for all practice locations noted as providing laboratory services.
- Ensure recredentialing files contain proof that the SCDHHS Excluded Provider List was queried.
- Develop a plan to monitoring the credentialing files for organizational providers to ensure all requirements are met.
- Ensure all Status 1 providers are included in evaluations of network adequacy.

Recommendations

- Document the credentialing committee's decision and the date of that decision in each recredentialing file.
- Revise the Medical Record Documentation Standards document on the website to mirror the standard on the audit tool and to include only those standards for which providers are responsible for including in medical records.
- Consider increasing the goals for appointment access for PCPs and specialty providers.

C. Member Services

The review of Member Services included policies and procedures, member rights, member informational materials, grievances, and the *Member Satisfaction Survey*. ATC's Member Handbook is thorough, easily understood, and meets the sixth-grade reading comprehension level required by SCDHHS. CCME noted the required font sizes for regular print and large print materials are documented in separate policies which may a barrier to meeting comprehensive contract requirements.

ATC's website has quick links and resources for members to access information such as the Member Handbook and Provider Directory. However, it was noted that information

for member grievances and preventive health guidelines are not found in easily accessible locations on the website. Members receive a Welcome Packet and Member Handbook with instructions for contacting Member Services, selecting a primary care provider (PCP), and initiating services. CCME could not identify, in the Member Handbook or in member newsletters, where members are notified of their right to request a copy of the Provider Directory annually.

The Member Handbook informs members about their rights and responsibilities, preventive health guidelines, appointment guidelines, and provides instructions on how to access benefits. Additionally, the handbook provides information on obtaining Advance Directives, requesting disenrollment, and how to access the Fraud and Abuse Hotline. The handbook is available in Spanish and alternate formats including large font, audio, and Braille.

Member Services staff are available per contract requirements via a toll-free number. The toll-free Member Services telephone number routes calls to Interactive Voice Response (IVR) menus that allow callers to reach appropriate staff during the hours of 8:00 a.m. to 6:00 p.m. Eastern Standard Time, Monday through Friday.

ATC contracts with SPH Analytics to conduct both the *Child* and *Adult Surveys*. Survey results were presented to the Quality Improvement Committees and to providers. The number of completed surveys did not meet the NCQA requirement for the Adult survey or the Child and Children with Chronic Conditions (CCC) surveys. CCME recommends ATC continue working with vendors to increase responses, as they are below the NCQA target response rate of 40%.

Processes for grievance handling and resolution are documented throughout policies, the Member Handbook, Provider Manual, and on ATC's website. Onsite discussion confirmed that expedited grievance processing is strictly an internal process followed when a need for expedited processing is identified by ATC. However, CCME noted the Member Handbook and Provider Manual instruct that members or their authorized representatives can request clinically-urgent grievance processing. CCME's review of grievance files found that grievance acknowledgements and resolutions were timely, and that appropriate internal referrals were made when potential quality of care issues were identified. One grievance file contained incomplete information in the resolution notice provided to the member.

As noted in *Figure 5*, 97% of the standards for Member Services are scored as "Met." One standard is scored as "Partially Met" due to erroneous grievance information in the Member Handbook and Provider Manual.

Figure 5: Member Services Findings

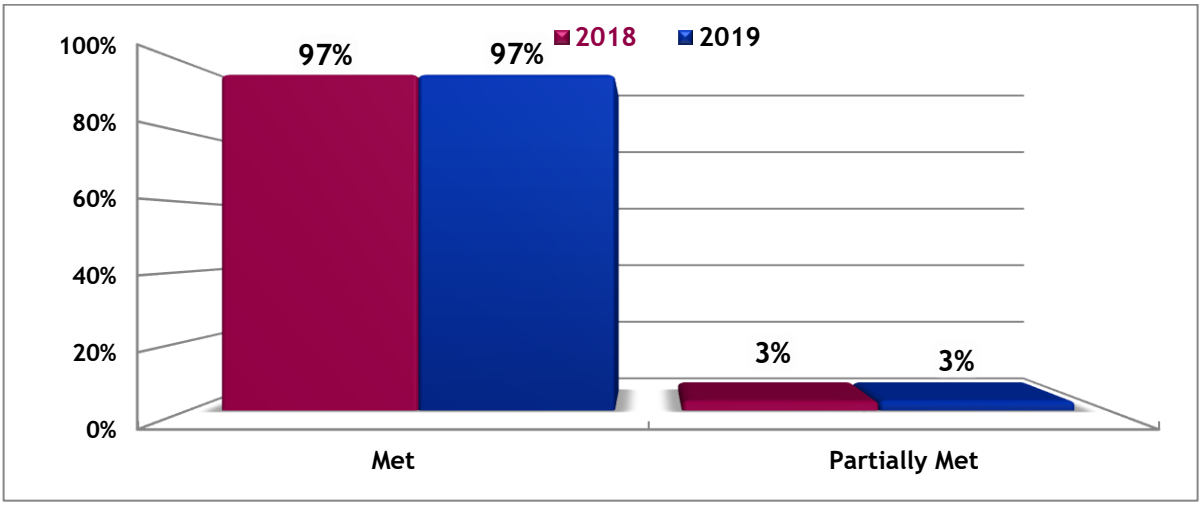


Table 9: Member Services Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Grievances	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 Procedures for filing and handling a grievance	Met	Partially Met
	The MCO applies grievance policies and procedures as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- Member newsletters include English and Spanish text within the same issue. This convenience eliminates members from calling Member Services to request a version in Spanish.
- ATC publishes an *Upbeat For Kids* newsletter, specifically geared for children, that includes cartoons and pages to color. It also includes English and Spanish text within the same issue.
- Grievance files reflect staff follow appropriate grievance processes. Acknowledgements and resolutions were timely and appropriate internal referrals were made when potential quality of care issues were identified.

Weaknesses

- The grievance information on the member website is located under the heading of "Complaints and Appeals" which is inconsistent with the verbiage in the Member Handbook, "Grievances and Appeals". Using different terms may prevent members from easily finding grievance information on the website.
- Members notified of their right to request a copy of the Provider Directory annually could not be identified.
- CCME could not identify how members are notified of changes in benefits at least 30 days before the effective date of a change.
- Policy SC.COMM.19, Member Materials Readability and Policy COMM.15 Request, Preparation, and Approval Process for Marketing and Communication Materials do not cross-reference each other to capture the requirements for font sizes, for large and regular print materials.
- Preventive health guidelines and recommendations on the website are located under the heading of "Quality Improvement Program" which is not readily accessible or easily recognizable to members. This observation was discussed during the 2018 EQR and a recommendation was made to address it at that time.
- Member satisfaction survey response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%.
- The Member Handbook, page 44, and the Provider Manual, page 89, state members or their authorized representatives can request clinically-urgent grievance processing. Onsite discussion confirmed this is incorrect and that expedited grievance processing is strictly an internal process followed when a need for expedited processing is identified.
- CCME's review of grievance files found that in one grievance file the documented resolution included that the provider, against whom the grievance was filed, does not bill out-of-state Medicaid and has financial assistance programs to assist with bill payment. However, onsite discussion revealed this member was not eligible with ATC on the date the services were provided to the member by the out-of-state provider. The resolution letter did not indicate that the member was not eligible with ATC on the date of service by the out-of-state provider.

Quality Improvement Plans

- Revise the Member Handbook, page 44, and the Provider Manual, page 89, to remove the information indicating members and their authorized representatives may request clinically-urgent grievance processing and resolution.

Recommendations

- Change the heading on the member website from "Complaints and Appeals" to "Grievances and Appeals" to be consistent with the verbiage in the Member Handbook.
- Ensure members are notified, at least once each calendar year, of their right to request a Member Handbook and Provider Directory as required in the *SCDHHS Contract, Section 3.13.2.18.*
- Document the process used to inform members of benefit changes 30 days before the effective date as required in the *SCDHHS Contract, Section 3.13.*
- To ensure all requirements in the *SCDHHS Contract, Section 3.15.1.3* are captured, include cross-references in the respective policies for Policy SC.COMM.19, Member Materials Readability and Policy COMM.15 Request, Preparation, and Approval Process for Marketing and Communication Materials.
- Place preventive health guidelines in a more prominent location on the website to allow members to more easily locate them.
- Continue to implement and develop methods to increase awareness and importance of the member satisfaction survey to members, such as adding reminders to the call center, maximizing the oversampling to increase response rates, and text reminders.
- Ensure grievance resolution letters contain full information so that members understand the resolution provided.

D. Quality Improvement

ATC's Quality Improvement (QI) Program operates under a plan of continuous improvement. The *2019 Quality Assessment and Performance Improvement Program Description Medicaid* describes the program's structure, accountabilities, scope, goals, and available resources. The Program Description is reviewed and updated at least annually.

Annually, ATC develops a QI Work Plan to guide and monitor activities for the year. The health plan provided the 2018 and 2019 QI Work Plans. Both work plans were complete and addressed the requirements.

ATC's Board of Directors has the ultimate authority and accountability for the oversight of the QI Program. The Board has delegated the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC provides oversight and directions in assessing the appropriateness of care and service delivery. ATC's Medical Director chairs the QIC and members include network practitioners specializing in pediatrics, OB/GYN, family medicine, internal medicine, and behavioral health. Other members include senior management and internal department staff. Per the QI Program Description, the

attendance requirement for the QIC is listed as 50% of meetings held. There were four voting members who did not meet this attendance requirement. CCME recommends ATC recruit additional voting members for the QIC.

ATC evaluated the QI Program and summarized the results of this evaluation in the *Quality Assessment and Performance Improvement Program Evaluation Medicaid – 2018*. Most of the program's objectives were met with areas not meeting the goals being analyzed and any interventions needed to improve performance identified.

Performance Measure Validation

CCME conducted a validation review of the HEDIS measures following Centers for Medicare & Medicaid Services (CMS) protocols. This process assesses the production of these measures by the health plan to confirm reported information is valid.

ATC uses Inovalon, a certified software organization, for calculation of HEDIS rates. CCME found the measures met all requirements. The HEDIS 2018 rate, the HEDIS 2019 rate, and the change in rates are presented in *Table 10: HEDIS Performance Measure Data*. The rates shown in green indicate a substantial (>10%) improvement and the rates shown in red indicate a substantial (>10%) decline.

Table 10: HEDIS Performance Measure Data

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
Effectiveness of Care: Prevention and Screening			
Adult BMI Assessment (aba)	87.83%	87.59%	-0.24%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	79.56%	84.18%	4.62%
Counseling for Nutrition	67.40%	67.40%	0.00%
Counseling for Physical Activity	63.02%	64.72%	1.70%
Childhood Immunization Status (cis)			
DTaP	75.43%	72.26%	-3.17%
IPV	89.54%	90.75%	1.21%
MMR	89.29%	87.59%	-1.70%
HiB	83.70%	82.48%	-1.22%
Hepatitis B	89.78%	90.27%	0.49%
VZV	89.54%	86.62%	-2.92%
Pneumococcal Conjugate	78.10%	78.35%	0.25%
Hepatitis A	84.91%	85.16%	0.25%
Rotavirus	74.70%	73.97%	-0.73%
Influenza	42.82%	39.90%	-2.92%

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
Combination #2	72.02%	67.88%	-4.14%
Combination #3	69.83%	65.94%	-3.89%
Combination #4	66.91%	64.96%	-1.95%
Combination #5	61.31%	57.18%	-4.13%
Combination #6	38.44%	32.85%	-5.59%
Combination #7	59.85%	56.69%	-3.16%
Combination #8	37.96%	32.60%	-5.36%
Combination #9	36.01%	28.95%	-7.06%
Combination #10	35.52%	28.71%	-6.81%
Immunizations for Adolescents (ima)			
Meningococcal	72.75%	74.45%	1.70%
Tdap/Td	85.64%	84.91%	-0.73%
Combination #1	71.53%	73.72%	2.19%
Combination #2	30.17%	30.66%	0.49%
Human Papillomavirus Vaccine for Female Adolescents (hpv)	31.63%	32.36%	0.73%
Lead Screening in Children (lsc)	67.40%	69.13%	1.73%
Breast Cancer Screening (bcs)	62.88%	64.56%	1.68%
Cervical Cancer Screening (ccs)	66.18%	65.94%	-0.24%
Chlamydia Screening in Women (chl)			
16-20 Years	55.24%	57.14%	1.90%
21-24 Years	65.17%	66.24%	1.07%
Total	58.52%	59.65%	1.13%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)	78.31%	79.47%	1.16%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	26.85%	21.86%	-4.99%
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	55.56%	66.50%	10.94%
Bronchodilator	78.46%	78.33%	-0.13%
Medication Management for People With Asthma (mma)			
5-11 Years - Medication Compliance 50%	51.77%	50.70%	-1.07%
5-11 Years - Medication Compliance 75%	23.31%	24.27%	0.96%
12-18 Years - Medication Compliance 50%	48.83%	45.36%	-3.47%
12-18 Years - Medication Compliance 75%	22.30%	23.30%	1.00%
19-50 Years - Medication Compliance 50%	56.52%	56.11%	-0.41%
19-50 Years - Medication Compliance 75%	31.68%	29.44%	-2.24%
51-64 Years - Medication Compliance 50%	62.22%	71.67%	9.45%
51-64 Years - Medication Compliance 75%	42.22%	50.00%	7.78%

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
Total - Medication Compliance 50%	51.75%	50.44%	-1.31%
Total - Medication Compliance 75%	24.72%	25.73%	1.01%
Asthma Medication Ratio (amr)			
5-11 Years	82.58%	83.04%	0.96%
12-18 Years	67.36%	72.66%	-3.47%
19-50 Years	53.36%	54.43%	1.00%
51-64 Years	60.66%	60.71%	-0.41%
Total	71.93%	73.84%	-2.24%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	40.88%	46.47%	5.59%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	51.35%	80.43%	**29.08%**
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - 21-75 years (Male)	76.64%	77.49%	0.85%
Statin Adherence 80% - 21-75 years (Male)	41.46%	50.84%	9.38%
Received Statin Therapy - 40-75 years (Female)	70.06%	72.73%	2.67%
Statin Adherence 80% - 40-75 years (Female)	30.65%	50.66%	**20.01%**
Received Statin Therapy - Total	73.66%	75.23%	1.57%
Statin Adherence 80% - Total	36.81%	50.76%	**13.95%**
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	89.23%	89.29%	0.06%
HbA1c Poor Control (>9.0%)	49.45%	42.34%	-7.11%
HbA1c Control (<8.0%)	40.88%	48.91%	8.03%
Eye Exam (Retinal) Performed	52.19%	57.91%	5.72%
Medical Attention for Nephropathy	93.80%	90.79%	-3.01%
Blood Pressure Control (<140/90 mm Hg)	40.88%	44.04%	3.16%
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	59.04%	60.74%	1.70%
Statin Adherence 80%	37.58%	45.55%	7.97%
Effectiveness of Care: Musculoskeletal Conditions			
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	61.83%	67.23%	5.40%
Effectiveness of Care: Behavioral Health			
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	39.15%	41.32%	2.17%
Effective Continuation Phase Treatment	22.92%	25.10%	2.18%

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	52.16%	53.06%	0.90%
Continuation and Maintenance (C&M) Phase	71.55%	63.59%	-7.96%
Follow-Up After Hospitalization for Mental Illness (fuh)			
6-17 years - 30-Day Follow-Up	NR	79.17%	NA
6-17 years - 7-Day Follow-Up	NR	40.63%	NA
18-64 years - 30-Day Follow-Up	NR	50.53%	NA
18-64 years - 7-Day Follow-Up	NR	24.73%	NA
65+ years - 30-Day Follow-Up	NR	NA	NA
65+ years - 7-Day Follow-Up	NR	NA	NA
Total - 30-Day Follow-Up	58.94%	55.40%	-3.54%
Total - 7-Day Follow-Up	36.46%	27.43%	-9.03%
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
6-17 years - 30-Day Follow-Up	NR	67.23%	NA
6-17 years - 7-Day Follow-Up	NR	40.90%	NA
18-64 years - 30-Day Follow-Up	NR	47.25%	NA
18-64 years - 7-Day Follow-Up	NR	30.75%	NA
65+ years - 30-Day Follow-Up	NR	NA	NA
65+ years - 7-Day Follow-Up	NR	NA	NA
Total - 30-Day Follow-Up	52.57%	56.67%	4.10%
Total - 7-Day Follow-Up	35.78%	35.54%%	-0.24%
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
*30-Day Follow-Up: 13-17 Years**	5.26%	12.90%	7.64%
*7-Day Follow-Up: 13-17 Years**	5.26%	6.45%	1.19%
30-Day Follow-Up: 18+ Years	11.19%	13.48%	2.29%
7-Day Follow-Up: 18+ Years	7.23%	9.43%	2.20%
30-Day Follow-Up: Total	10.94%	13.43%	2.49%
7-Day Follow-Up: Total	7.14%	9.20%	2.06%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	74.20%	75.19%	0.99%
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	65.00%	61.93%	-3.07%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)*	86.67%	47.83%	-38.84%*
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	58.35%	62.93%	4.58%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
*1-5 Years**	NA	NA	NA
6-11 Years	22.61%	25.69%	3.08%

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
12-17 Years	26.67%	35.79%	9.12%
Total	24.92%	32.00%	7.08%
Effectiveness of Care: Medication Management			
Annual Monitoring for Patients on Persistent Medications (mpm)			
ACE Inhibitors or ARBs	90.36%	88.29%	-2.07%
Diuretics	89.53%	88.89%	-0.64%
Total	89.99%	88.57%	-1.42%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	1.89%	2.22%	0.33%
Appropriate Treatment for Children With URI (uri)	87.43%	89.11%	1.68%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	32.05%	30.38%	-1.67%
Use of Imaging Studies for Low Back Pain (lbp)	66.53%	65.52%	-1.01%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)			
*1-5 Years**	NA	NA	NA
6-11 Years	0.00%	0.00%	NA
12-17 Years	0.82%	1.53%	0.71%
Total	0.49%	.94%	0.45%
Use of Opioids at High Dosage (uod)	44.26	4.65%	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	245.27	17.64%	NA
Multiple Pharmacies	77.63	7.78%	NA
Multiple Prescribers and Multiple Pharmacies	46.58	2.91%	NA
Risk of Continued Opioid Use (cou)			
18-64 years - >=15 Days covered	NQ	2.59%	NA
18-64 years - >=31 Days covered	NQ	1.01%	NA
65+ years - >=15 Days covered	NQ	NA	NA
65+ years - >=31 Days covered	NQ	NA	NA
Total - >=15 Days covered	NQ	2.59%	NA
Total - >=31 Days covered	NQ	1.01%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
20-44 Years	76.43%	76.47%	0.04%
45-64 Years	86.16%	85.16%	-1.00%
*65+ Years**	80.00%	100%	20.00%
Total	79.27%	79.17%	-0.10%
Children and Adolescents' Access to Primary Care Practitioners (cap)			

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
12-24 Months	95.51%	96.55%	1.04%
25 Months - 6 Years	84.75%	85.33%	0.58%
7-11 Years	88.11%	88.13%	0.02%
12-19 Years	86.74%	86.86%	0.12%
Initiation and Engagement of AOD Dependence Treatment (iet)			
*Alcohol abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	35.71%	NA
*Alcohol abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	21.43%	NA
*Opioid abuse or dependence: Initiation of AOD Treatment: 13-17 Years**	NA	33.33%	NA
*Opioid abuse or dependence: Engagement of AOD Treatment: 13-17 Years**	NA	16.67%	NA
Other drug abuse or dependence: Initiation of AOD Treatment: 13-17 Years	33.55%	35.34%	1.79%
Other drug abuse or dependence: Engagement of AOD Treatment: 13-17 Years	23.23%	23.31%	0.08%
Initiation of AOD Treatment: 13-17 Years	31.52%	34.69%	3.17%
Engagement of AOD Treatment: 13-17 Years	21.82%	21.77%	-0.05%
Alcohol abuse or dependence: Initiation of AOD Treatment: 18+ Years	44.53%	44.78%	0.25%
Alcohol abuse or dependence: Engagement of AOD Treatment: 18+ Years	7.75%	9.20%	1.45%
Opioid abuse or dependence: Initiation of AOD Treatment18+ Years	51.12%	39.50%	**-11.62%**
Opioid abuse or dependence: Engagement of AOD Treatment: 18+ Years	21.35%	14.25%	-7.10%
Other drug abuse or dependence: Initiation of AOD Treatment: 18+ Years	43.10%	42.77%	-0.33%
Other drug abuse or dependence: Engagement of AOD Treatment: 18+ Years	11.31%	11.21%	-0.10%
Initiation of AOD Treatment: 18+ Years	43.25%	41.30%	-1.95%
Engagement of AOD Treatment: 18+ Years	10.90%	10.55%	-0.35%
Alcohol abuse or dependence: Initiation of AOD Treatment: Total	44.06%	44.44%	0.38%
Alcohol abuse or dependence: Engagement of AOD Treatment: Total	7.80%	9.66%	1.86%
Opioid abuse or dependence: Initiation of AOD Treatment: Total	51.12%	39.41%	**-11.71%**
Opioid abuse or dependence: Engagement of AOD Treatment: Total	21.23%	14.29%	-6.94%

MEASURE/DATA ELEMENT	HEDIS 2018	HEDIS 2019	PERCENTAGE POINT DIFFERENCE
Other drug abuse or dependence: Initiation of AOD Treatment: Total	41.90%	41.91%	0.01%
Other drug abuse or dependence: Engagement of AOD Treatment: Total	12.80%	12.61%	-0.19%
Initiation of AOD Treatment: Total	42.32%	40.82%	-1.50%
Engagement of AOD Treatment: Total	11.76%	11.38%	-0.38%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	90.51%	91.48%	0.97%
Postpartum Care	66.42%	67.40%	0.98%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
*1-5 Years**	NA	NA	NA
6-11 Years	54.10%	52.36%	-1.74%
12-17 Years	63.27%	52.58%	**-10.69%**
Total	58.90%	52.52%	-6.38%
Utilization			
Well-Child Visits in the First 15 Months of Life (w15)			
0 Visits	1.46%	2.19%	0.73%
1 Visit	0.24%	0.49%	0.25%
2 Visits	2.92%	2.68%	-0.24%
3 Visits	4.38%	3.41%	-0.97%
4 Visits	9.00%	8.52%	-0.48%
5 Visits	13.63%	14.36%	0.73%
6+ Visits	68.37%	68.37%	0.00%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	65.94%	63.75%	-2.19%
Adolescent Well-Care Visits (awc)	53.28%	55.96%	2.68%

*Note. * indicates small denominator; NR= not reported; NA= not applicable; NQ= not required*

The comparison from the previous to the current year revealed a strong increase (>10%) in several rates, including Systemic Corticosteroids and Persistence of Beta Blocker Treatment for those managing COPD, 80% Statin Adherence for female Cardiovascular Disease patients ages 40-75 years old, and overall 80% Statin Adherence. The measures that decreased substantially (>10%) were Initiation of AOD Treatment for those 18 and older and who have opioid dependence, and the Total Opioid Initiation rate. As well, Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics decreased substantially for 12-17 year olds. *Table 11: HEDIS Measures with Substantial Changes in Rates* highlights the HEDIS measures with substantial increases or decreases in rate from last year to the current year.

Table 11: HEDIS Measures with Substantial Changes in Rates

MEASURE/DATA ELEMENT	MEASURE YEAR 2018	MEASURE YEAR 2019	CHANGE FROM 2018 TO 2019
Substantial Increase in Rate (>10% improvement)			
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	55.56%	66.50%	10.94%
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	51.35%	80.43%	29.08%
Statin Therapy for Patients with Cardiovascular Disease (spc)			
Statin Adherence 80% - 40-75 years (Female)	30.65%	50.66%	20.01%
Statin Adherence 80% - Total	36.81%	50.76%	13.95%
Substantial Decrease in Rate (>10% decrease)			
Initiation and Engagement of AOD Dependence Treatment (iet)			
Opioid abuse or dependence: Initiation of AOD Treatment: Total	51.12%	39.41%	-11.71%
Opioid abuse or dependence: Initiation of AOD Treatment 18+ Years	51.12%	39.50%	-11.62%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
12-17 Years	63.27%	52.58%	-10.69%

Quality Withhold Measures

ATC reported 12 quality clinical withhold measures for 2018. The Behavioral Health measures are considered Bonus Only for 2018. As per the *Medicaid Playbook* and *Managed Care Organizations Policy and Procedure Guide*, individual measures within the quality index are weighted differently. A point value is assigned for each measure based on percentile (<10 Percentile = 1 point; 10-24 Percentile = 2 points; 25-49 Percentile = 3 points; 50-74 Percentile = 4 points; 75-90 Percentile = 5 points; >90 Percentile = 6 points). Points attained for each measure are multiplied by the individual measure's weight then summed to obtain quality index score. The 2018 rate, percentile, point value, and index score are shown in *Table 12: Quality Withhold Measures*. The Women's Health measure rates generated the highest index score, followed by Diabetes, and then Pediatric Preventive Care.

Table 12: Quality Withhold Measures

MEASURE	2018 RATE	2018 PERCENTILE	POINT VALUE	INDEX SCORE
DIABETES				
Hemoglobin A1c (HbA1c) Testing	89.29%	90	6	4.45
HbA1c Control (>9)	42.34%	25	3	
Eye Exam (Retinal) Performed	57.91%	75	5	
Medical Attention for Nephropathy	90.79%	25	3	
WOMEN'S HEALTH				
Timeliness of Prenatal Care	91.48%	90	6	5.10
Breast Cancer Screen	64.09%	75	5	
Cervical Cancer Screen	65.94%	75	5	
Chlamydia Screen in Women (Total)	59.65%	50	4	
PEDIATRIC PREVENTIVE CARE				
6+ Well-Child Visits in First 15 months of Life	68.37%	50	4	3.30
Well Child Visits in 3rd,4th,5th&6th Years of Life	63.75%	10	2	
Adolescent Well-Care Visits	55.96%	50	4	
Weight Assessment/Adolescents: BMI % Total	84.18%	75	5	
BEHAVIORAL HEALTH				
Follow-Up After Hospitalization for Mental Illness - 7 Days	27.43%	10	2	3.25
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment - Initiation - Total	40.82%	25	3	
Follow Up for Children Prescribed ADHD Medication - Initiation	53.06%	75	5	
Continuation Phase-Antidepressant Medication Management - 180 Days (6 Months)	25.1%	<10	1	
Metabolic Monitoring for Children & Adolescents on Antipsychotics - Total	32.00%	50	4	
Use of First-Line Psychosocial Care for Children & Adolescents on Antipsychotics - Total	52.52%	10	2	

Performance Improvement Project Validation

The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the CMS-developed protocol entitled, *EQR Protocol 3: Validating Performance Improvement Projects Version 2.0, September 2012*. The protocol validates project components and its documentation to provide an assessment of the overall study design and project methodology. The components assessed include the following:

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

ATC submitted two projects for validation. They included Postpartum Care and Provider Satisfaction. All PIPs received a sore within the High Confidence Range. *Table 13: Performance Improvement Project Validation Scores* provides an overview of the validation scores.

TABLE 13: Performance Improvement Project Validation Scores

PROJECT	2018 VALIDATION SCORE	2019 VALIDATION SCORE
Postpartum Care	98/98=100% High Confidence in Reported Results	111/111=100% High Confidence in Reported Results
Provider Satisfaction	87/88=99% High Confidence in Reported Results	104/105=99% High Confidence in Reported Results

It was noted the rate decreased from baseline to follow-up for the Provider Satisfaction PIP. This was discussed during the onsite and ATC indicated a workgroup met to review and discuss the decrease in the rate. Additional training was provided to provider relations and call center staff to cover areas of provider concerns. ATC also implemented the Interpreta application that allows network providers to receive real-time analysis of care gaps and will host semiannual regional meetings and quarterly meetings to strengthen and enhance the existing interventions.

There are no corrective actions for the PIPs and one recommendation for the Provider Satisfaction PIP, as displayed in *Table 14: Performance Improvement Project Recommendations*.

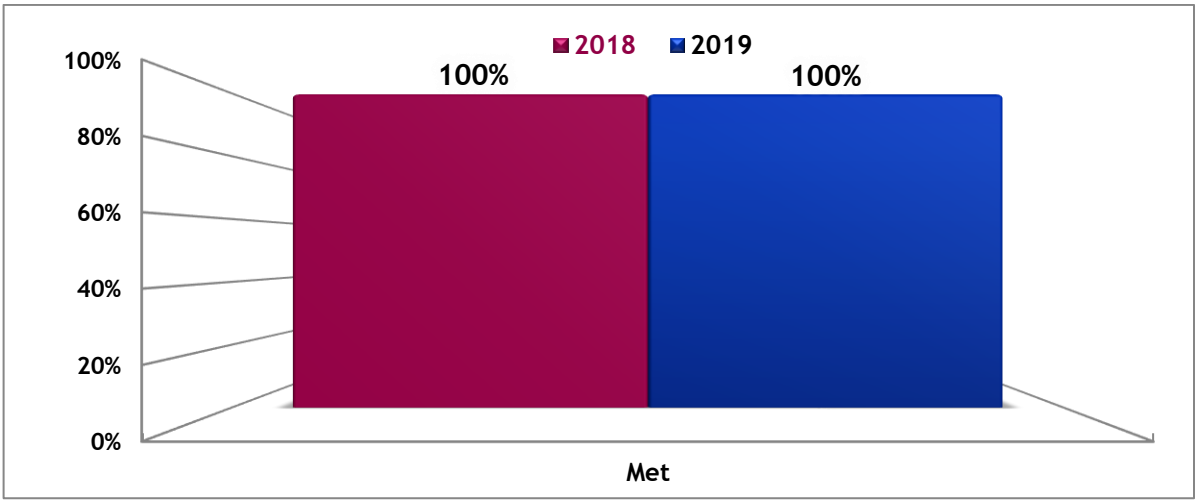
TABLE 14: Performance Improvement Project Recommendations

PROJECT	SECTION	REASONING	RECOMMENDATION
Provider Satisfaction	Was there any documented, quantitative improvement in processes or outcomes of care?	Rate decreased from baseline to follow-up for provider satisfaction.	Continue interventions such as workgroups and staff education to impact provider satisfaction.

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

All Standards in the QI section received a "Met" score. *Figure 6: Quality Improvement Findings* provides an overview of the scores in 2018 compared to the current review scores.

Figure 6: Quality Improvement Findings



Strengths

- All the requirements in the Quality Improvement section of this EQR received a "Met" score.
- The performance improvement projects received a validation score in the High Confidence Range.

Weaknesses

- Per the QI Program Description, the attendance requirement for the QIC is listed as 50% of meetings held. There were four voting members who did not meet this attendance requirement.

- The performance rate for the Provider Satisfaction performance improvement project decreased from baseline to follow-up.

Recommendations:

- Recruit additional voting members for the Quality Improvement Committee.
- Continue interventions such as workgroups and staff education to impact provider satisfaction.

E. Utilization Management

CCME's assessment for Utilization Management (UM) includes reviews of program descriptions and evaluations, policies, Member Handbook, Provider Manual, a sample of approval, denial, appeal and case management files, and the website. The *UM Program Description* and policies provide guidance to staff conducting UM activities for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina.

Review of pharmacy documents revealed issues such as: the timeframe and communication method for PDL changes in Policy CC.PHAR.10, Preferred Drug List are inconsistent with ATC's processes, the *Preferred Drug List Updates* posted on the website are not prominent, and the 30-day timeframe documented in the Pharmacy Program Description allowing new members to fill prescriptions needing prior authorization is not consistent with the 90-day timeframe requirement in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.21.3.*

Service authorization requests are conducted by appropriate reviewers using both InterQual criteria and other established criteria. ATC assesses consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing of both physician, non-physician, and pharmacy staff reviewers. CCME's review of approval and denial files found timely and consistent decision-making. However, there is one denial file where the reviewer documented the submitted clinical notes were incomplete however, there was no evidence that additional clinical notes were requested before rendering a determination.

Policy SC.UM.13, Member Appeals includes requirements and ATC's processes for receiving, reviewing, and resolving member appeals. Information about appeals is also included in the Member Handbook, Provider Manual, and on ATC's website. Issues identified in documentation of appeals processes and requirements include incomplete information about requirements following denial of a request for expedited appeal resolution, incomplete information about how members are supplied with the appeal case file and related documents, and discrepant information about requesting a State Fair

Hearing. CCME's review of appeal files confirmed staff follow appropriate processes for receiving, reviewing, and resolving appeals.

ATC uses care management techniques to ensure comprehensive, coordinated care for all members in various risk levels. CM files indicate care management activities are conducted as required and Care Managers follow policies to conduct the appropriate level of care coordination. HIPAA verification, identifying care-gaps, and social determinants of health are consistently addressed during member outreach.

ATC analyzed and monitored data for several services regarding utilization and offered recommendations based on findings in the committee meetings and in the program evaluations. From a population health perspective, member readmission and length-of-stay (LOS) may be impacted by certain diseases. CCME recommends the plan consider a performance improvement project that focuses on diseases related to length-of-stay or readmissions.

As noted in *Figure 7: Utilization Management Findings*, ATC achieved "Met" scores for 98% of the Utilization Management standards.

Figure 7: Utilization Management Findings

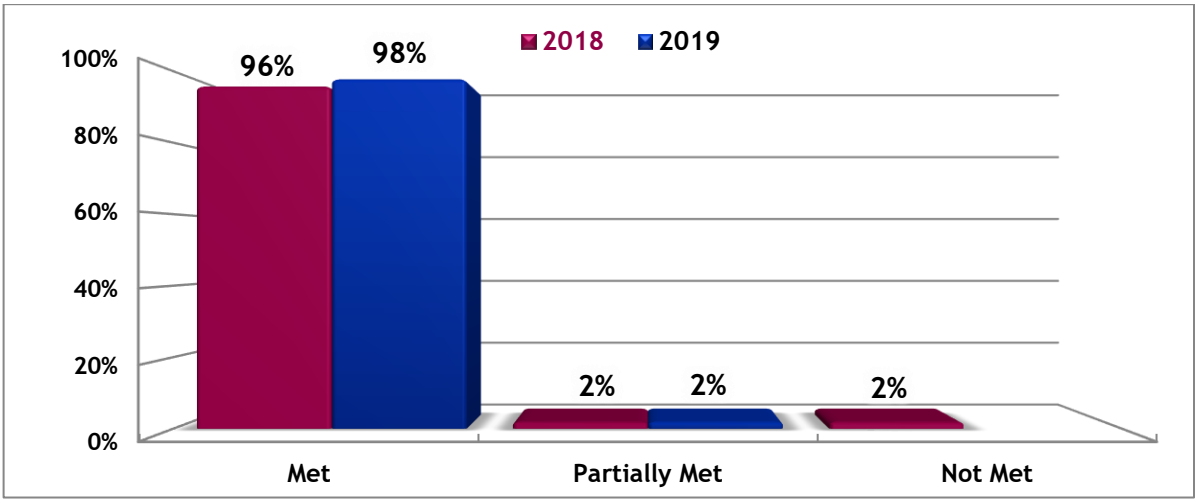


TABLE 15: Utilization Management Comparative Data

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Pharmacy Requirements	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2018 to 2019.

Strengths

- The list of UM Physician reviewers reflects a diversity in clinical specialties.
- Denial notices to members were written clearly in language that is easily understood.
- CCME's review of appeals files confirmed staff follow appropriate processes for receiving, reviewing, and resolving appeals.

Weaknesses

- Policy CC.PHAR.10, Preferred Drug List, page 3, indicates that PDL changes are communicated annually and that negative PDL changes are only communicated to the member and their provider. However, the timeframe and communication method in the policy are not consistent with ATC's processes identified in the EQR, which is to communicate PDL changes 30 days before the effective date and post it on the website.
- A *Preferred Drug List Updates* document is posted on the website under the heading "Which Drugs Are Covered". This is not a prominent and easily accessible location for members to find PDL changes.
- The *Pharmacy Program Description*, page 10, states ATC allows 30 days for new members to fill prescriptions that require prior authorization. However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.21.3* states, "the new MCO is required to honor existing prescriptions needing a Prior Authorization (PA) under the new plan's formulary for a period of no less than ninety (90) days." ATC staff confirmed that they received permission from SCDHHS to authorize prescriptions for new members for 30 days and 60 days when appropriate.
- Overall, denial files reflect additional information is requested when necessary to complete service determinations. However, in one file, the reviewer documented the clinical notes were incomplete and there was no evidence that additional clinical notes were requested before rendering a determination.
- Onsite discussion confirmed ATC requires members to submit a written appeal request following denial of expedited processing when the appeal was requested verbally. However, this requirement is not included in Member Handbook, Provider Manual, or in the Expedited Appeal Denial letter template.
- Regarding a member request to review the case file and other documents related to an appeal, ATC staff confirmed that the information would be supplied to the member via certified mail. However, the Appeal Acknowledgement letter template does not indicate that the information will be provided to the member by mail. The letter template states, "If you want to come in and look at your file, please call us." This language could be interpreted to mean that the member must come to ATC to view the material.

- The "Filing an Appeal" page on ATC's website contains conflicting information about requesting a State Fair Hearing. Under the heading "Member Rights to State Fair Hearing" it correctly states members must request a State Fair Hearing in writing. However, under the heading "What if I am still not satisfied?" on the same page it states "…you can ask for a State Fair Hearing with SCDHHS by contacting the Division of Appeals and Hearings at 803-898-2600."

Quality Improvement Plans

- To be consistent with ATC's processes and with requirements in the *SCDHHS Contract, Section 4.2.21.2.3*, edit page 3 of Policy CC.PHAR.10, Preferred Drug List to reflect that PDL changes are posted to the website 30 days before the intended effective date in addition to notifying the impacted member and provider.

Recommendations

- Place the *Preferred Drug List Updates* document in prominent and easily accessible location on the website, such as near the PDL document.
- Edit the ATC Pharmacy Program description, page 10, to indicate ATC will honor existing prescriptions needing prior authorization under ATC's formulary for a period of no less than 90 days, as noted in the SCDHHS *Policy and Procedure Guide for Managed Care Organizations*, Section 4.2.21.3.
- Ensure additional clinical information is requested when reviewers identify the submitted provider's notes are incomplete.
- Revise the Member Handbook, Provider Manual, and Expedited Appeal Denial letter template to include the requirement that a written appeal request is required following the denial of expedited processing when the appeal was requested verbally.
- Revise the Appeal Acknowledgement letter template to clearly indicate how members can view the case file and other documents related to an appeal.
- Revise the website to clearly convey that all requests for State Fair Hearings must be in writing.
- Conduct analysis to determine if a performance improvement project, that focuses on diseases related to length-of-stay or readmissions, is warranted. Consider how factors such as care coordination or adherence impact length-of-stay and member readmissions .

F. Delegation

CCME's review of delegation functions examined the submitted delegate list, delegation monitoring materials, and delegation contracts.

ATC reported several current delegation agreements, as shown in *Table 16: Delegated Entities and Services*.

Table 16: Delegated Entities and Services

Delegated Entities	Delegated Services
National Imaging Associates (NIA)	Radiology - UM; Credentialing/Recredentialing; Network Development & Maintenance
Envolve PeopleCare (Legacy Nutur & NurseWise)	Disease Management and Nurse Hotline
Envolve Vision	Vision - Claims Adjudication; Credentialing/ Recredentialing; Network Development & Maintenance
Envolve Pharmacy	Pharmacy Benefit Management - UM; Claims Adjudication; Network Development & Maintenance
CVS Minute Clinic, AU Medical Center/Medical College of Georgia, Greenville Health Systems, Health Network Solutions, Management Network Services, Regional Health Plus Spartanburg, Medical University of South Carolina, Preferred Care of Aiken, St. Francis Physician Services, Inc., Palmetto Health USC, AnMed Health, Roper St Francis, Lexington County Health Services District, and Bon Secours Ambulatory Services	Credentialing/Recredentialing

Pre-delegation and annual oversight monitoring were provided for all delegated entities. Deficiencies identified during monitoring required the entity to complete a corrective action plan. The monitoring report and the oversight letter indicated follow-up for the corrective action items would not occur until the next annual monitoring.

All the standards received a "Met" score in the Delegation section as noted in *Figure 8: Delegation Findings*

Figure 8: Delegation Findings

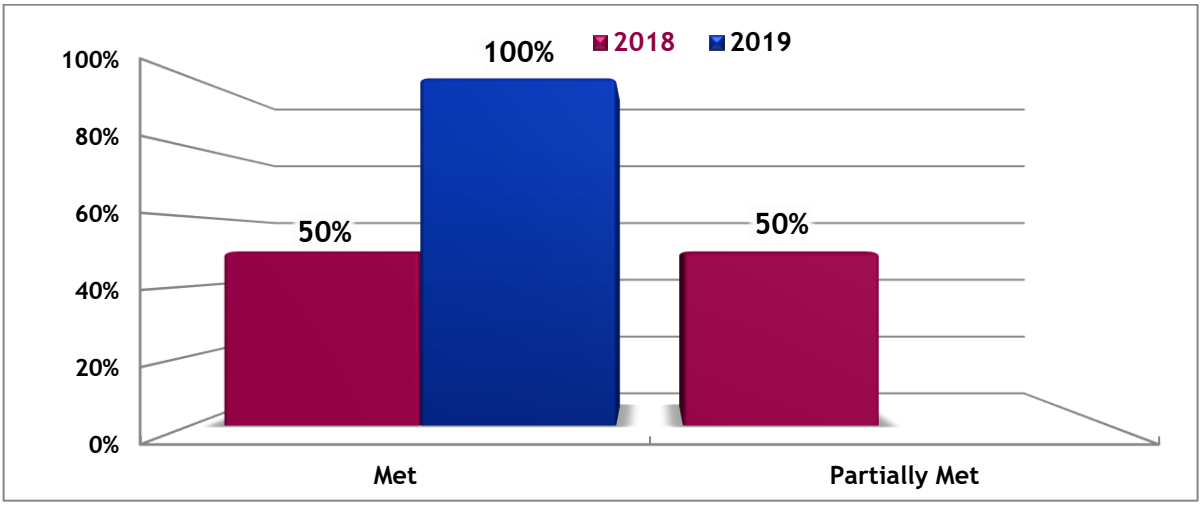


TABLE 17: DELEGATION

SECTION	STANDARD	2018 REVIEW	2019 REVIEW
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2017 to 2018.

Weaknesses

- Deficiencies identified during the monitoring required the entity to complete a corrective action plan. The monitoring report and the oversight letter indicated follow-up for the corrective action items would not occur until the next annual monitoring.

Recommendation

- ATC should follow-up on deficiencies identified during pre-delegation and annual oversight monitoring before the next annual monitoring is conducted.

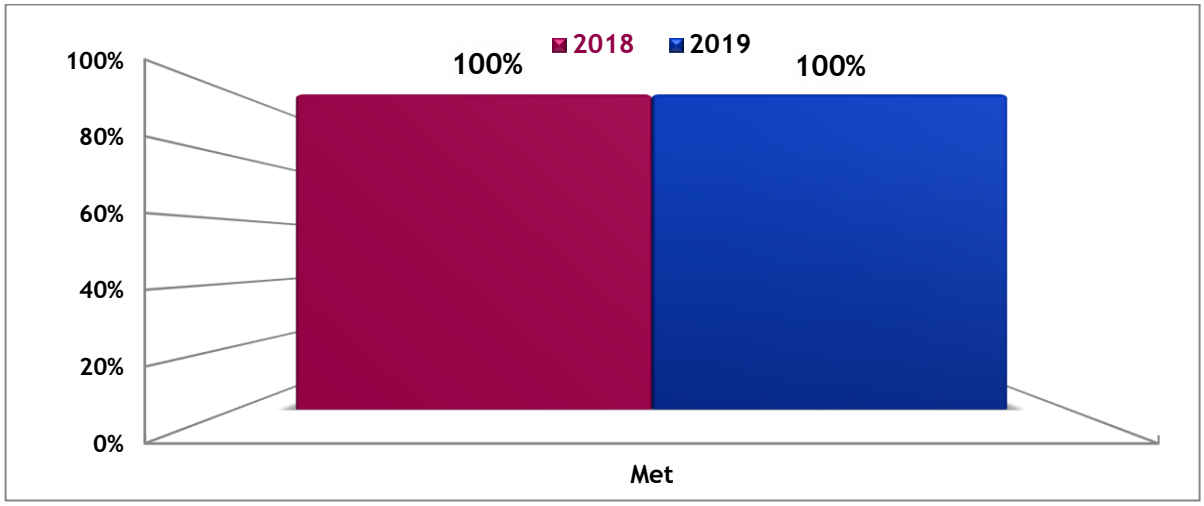
G. State Mandated Services

ATC's EPSDT Program follows the American Academy of Pediatrics periodicity schedule for required screenings and health treatments. The plan monitors compliance with immunization and EPSDT requirements by reviewing PCP rates for immunization and well-

child visits and through random medical record reviews. The *EPSDT Tool Kit* and sending monthly membership lists of missed or upcoming services to providers are examples of how ATC ensures EPSDT services for members through the month of their 21st birthday.

ATC provides all core benefits specified by the *SCDHHS Contract*. *Figure 9: State Mandated Services* shows all standards were met.

Figure 9: State Mandated Services



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

December 2, 2019

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

Dear Mr. McClellan:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2019 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The CCME EQR team plans to conduct the onsite visit on **February 26th and 27th.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **December 16, 2019.**

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

https://eqro.thecarolinascenter.org

I have included written instructions on how to use the file transfer site and would be happy to answer any questions on how to utilize the file transfer site if needed. An opportunity for a conference call with your staff, to describe the review process and answer any questions prior to the onsite visit, is being offered as well. Please contact me directly at 803-212-7582 if you would like to schedule time for either of these conversational opportunities.

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2019

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.

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 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, and Pharmacy Programs.

10. The Quality Improvement work plans for 2018 and 2019.

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 those 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.

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

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

18. A complete list of all members enrolled in the case management program from December 2018 through November 2019. 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 survey, a copy of the tool and methodology used. If the survey was performed by a subcontractor, please include a copy of the contract, final report provided by the subcontractor, and other documentation of the requested scope of work.

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

23. A copy of the Grievance, Complaint and Appeal logs for the months of December 2018 through November 2019.

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 practice 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, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to 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. Please include the Quality Compass percentile, point value, and index scores for the SCDHHS withhold measures.

36. Provide electronic copies of the following files:
    a. Credentialing files (<u>including signed Ownership Disclosure Forms</u>) for:
        i. Ten PCP's (Include two NP's acting as PCP's, 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 (<u>including signed Ownership Disclosure Forms</u>) files for:
        i. Ten PCP's (Include two NP's acting as PCP's, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty medical necessity denial files (acute inpatient, outpatient and behavioral health) made in the months of December 2018 through November 2019. Include any medical information and physician review documentations used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient and behavioral health) made in the months of December 2018 through November 2019, 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: Appeals, Grievances, 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://egro.thecarolinascenter.org

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2019

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. The current Medicaid Orientation presentation. The Medicaid Orientation dated October 2017 was provided.
3. Additional information for the credentialing and recredentialing files on the attached list.
4. A copy of the Business Ethics and Code of Conduct.
5. A copy of the Q4 2018 Compliance Committee meeting minutes.
6. An updated EPSDT Program Description. The document on the website is dated 2018 and a copy was not attached to Policy SC.QI.25 - EPSDT Policy.
7. A copy of the letter templated used to notify members of their placement into the Pharmacy Lock-in Program.
8. Any network adequacy, accessibility, etc. evaluations/documentation for 2019.
9. Any documentation/results of provider medical record review audits conducted in 2019.
10. Attachment A (Medical Record Review Tool) of Policy SC.QI.13, Medical Record Review.
11. Copies of the monthly Credentialing Program Quality Monitoring, referenced in policy CC. CRED.11, conducted in the months of August 2019 – January 2020.
12. Copy of Policy CP.CPC.05 – Medical Necessity Criteria.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

Plan Name:	**ATC**
Name of PIP:	**PROVIDER SATISFACTION (NON-CLINICAL)**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE STUDY METHODOLOGY

Component / Standard (Total Points)	Score	Comments
STEP 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? **(5)**	**MET**	ATC provider rating of health plan was below the target rate.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	This PIP addressed enrollee care and services.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	All targeted populations were included.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was stated clearly in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	Indicator was clearly defined.
3.2 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**	Indicator measured changes in provider satisfaction.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captured the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used the NCQA protocol for sampling.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used the NCQA protocol for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used the NCQA protocol for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were documented.
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**	Design was systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were adequate and valid.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	The Data Analysis Plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	A qualified vendor collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions and barriers were documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Findings are presented in Tables and graphs throughout report. Main outcome is presented in report.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and 2019 rates were presented.
8.4 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 findings was documented.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Methodology for survey was the same.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Rate decreased from baseline to follow-up for provider satisfaction. ***Recommendation: Continue interventions such as workgroups and staff education to impact provider satisfaction.***
9.3 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**	No improvement reported.

Component / Standard (Total Points)	Score	Comments
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	No improvement reported.
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	No improvement reported.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	**NA**

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	0
9.3	NA	NA
9.4	NA	NA
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	104
Project Possible Score	105
Validation Findings	99%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
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:	**ATC**
Name of PIP:	**POST PARTUM CARE**
Reporting Year:	**2019**
Review Performed:	**2020**

ACTIVITY 1: ASSESS THE STUDY 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 Health Plan's 2018 HEDIS hybrid rate for postpartum care was 66.42% which was below the 2017 NCQA Quality Compass 75th percentile.
1.2 Did the MCO's/PIHP's PIPs, over time, address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	PIP addressed a key aspect of enrollee care.
1.3 Did the MCO's/PIHP's PIP/FSs, over time, include all enrolled populations (i.e., did not exclude certain enrollees such as those with special health care needs)? **(1)**	**MET**	PIP included relevant population.
STEP 2: Review the Study Question(s)		
2.1 Was/were the study question(s) stated clearly in writing? **(10)**	**MET**	Research question was stated clearly in PIP report.
STEP 3: Review Selected Study Indicator(s)		
3.1 Did the study use objective, clearly defined, measurable indicators? **(10)**	**MET**	The indicator was a HEDIS measure.
3.2 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 indicator measured changes in health status.
STEP 4: Review The Identified Study Population		
4.1 Did the MCO/PIHP clearly define all Medicaid enrollees to whom the study question and indicators are relevant? **(5)**	**MET**	Enrollees were defined.
4.2 If the MCO/PIHP studied the entire population, did its data collection approach truly capture all enrollees to whom the study question applied? **(1)**	**MET**	Data captured the relevant population sector.
STEP 5: Review Sampling Methods		
5.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? **(5)**	**MET**	The study used HEDIS guidelines for sampling. Margin of error was reported.
5.2 Did the MCO/PIHP employ valid sampling techniques that protected against bias? **(10)** *Specify the type of sampling or census used:*	**MET**	The study used HEDIS guidelines for sampling.
5.3 Did the sample contain a sufficient number of enrollees? **(5)**	**MET**	The study used HEDIS guidelines for sampling.

Component / Standard (Total Points)	Score	Comments
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data to be collected were clearly specified.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Sources of data were documented.
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**	Design was systematic in collecting valid and reliable data.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Instruments for data collection were adequate.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data Analysis Plan was documented.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	The study documented qualified staff collected the data.
STEP 7: Assess Improvement Strategies		
7.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? **(10)**	**MET**	Interventions to address barriers were documented.
STEP 8: Review Data Analysis and Interpretation of Study Results		
8.1 Was an analysis of the findings performed according to the data analysis plan? **(5)**	**MET**	Analyses were performed according to the Data Analysis Plan.
8.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	PIP results were presented clearly and accurately.
8.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? **(1)**	**MET**	Baseline and one repeat measurement were documented.
8.4 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**	Interpretation of the findings was provided.
STEP 9: Assess Whether Improvement Is "Real" Improvement		
9.1 Was the same methodology as the baseline measurement, used, when measurement was repeated? **(5)**	**MET**	Same methodology was used.
9.2 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**MET**	Rate improved from 66.42 to 67.40
9.3 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**MET**	Improvement appears to be related to interventions taken.
9.4 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**MET**	Statistical analysis was provided, although p-value was not significant.

Component / Standard (Total Points)	Score	Comments
STEP 10: Assess Sustained Improvement		
10.1 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Unable to judge.

ACTIVITY 2: VERIFYING STUDY FINDINGS

Component / Standard (Total Score)	Score	Comments
Were the initial study findings verified upon repeat measurement? **(20)**	**NA**	Not Applicable.

ACTIVITY 3: EVALUATE OVERALL VALIDITY & RELIABILITY OF STUDY RESULTS

SUMMARY OF AGGREGATE VALIDATION FINDINGS AND SUMMARY

Steps	Possible Score	Score
Step 1		
1.1	5	5
1.2	1	1
1.3	1	1
Step 2		
2.1	10	10
Step 3		
3.1	10	10
3.2	1	1
Step 4		
4.1	5	5
4.2	1	1
Step 5		
5.1	5	5
5.2	10	10
5.3	5	5
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1

Steps	Possible Score	Score
Step 6		
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	10	10
Step 8		
8.1	5	5
8.2	10	10
8.3	1	1
8.4	1	1
Step 9		
9.1	5	5
9.2	1	1
9.3	5	5
9.4	1	1
Step 10		
10.1	NA	NA
Verify	NA	NA

Project Score	111
Project Possible Score	111
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE

AUDIT DESIGNATION POSSIBILITIES	
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:	**ATC**
Name of PM:	**HEDIS 2019**
Reporting Year:	**MY2018**
Review Performed:	**2020**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS 2019 Technical Specifications

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

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 used correct data sources.
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**	Denominator was calculated accurately.

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 used correct data sources.
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**	Numerator was calculated accurately.
N3. Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**MET**	Documentation was adequate.
N4. Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**MET**	Documentation was adequate.
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**	Documentation was adequate.

SAMPLING ELEMENTS (if Administrative Measure then N/A for section)			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
S1. Sampling	Sample was unbiased.	**MET**	Sampling was appropriate.
S2. Sampling	Sample treated all measures independently.	**MET**	Sampling performed appropriately.
S3. Sampling	Sample size and replacement methodologies met specifications.	**MET**	Sample size met specifications.

REPORTING ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
R1. Reporting	Was the measure reported accurately?	**MET**	Measures were reported accurately.
R2. Reporting	Was the measure reported according to State/HEDIS specifications?	**MET**	Measures were reported according to HEDIS specifications.

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
S3	5	MET	5
R1	10	MET	10
R2	5	MET	5

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	**85**
Measure Weight Score	**85**
Validation Findings	**100%**

AUDIT DESIGNATION
FULLY COMPLIANT

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

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID ADULT 5.0H**
Validation Period	2019
Review Performed	2020

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

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 statement of purpose was documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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**	Definition of the study population was clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 1,809. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate were noted. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report* *August 2019 QIC Minutes*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •Morpace, as a vendor, provides a full report of process and results that meet the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.

	Results Elements	Validation Comments And Conclusions
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 17% (n=303 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was not met, nor the NCQA target response rate.
7.4	What conclusions are drawn from the survey data?	Key topics were Getting Care as Soon as Needed and Easy to Get Care Believed Necessary. Documentation: *CAHPS Workbook*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2019 CAHPS® Adult Medicaid Survey Summary Report*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID CHILD 5.0H**
Validation Period	2019
Review Performed	2020

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

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 statement of purpose was documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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**	Definition of the study population was clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error, Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 2,545. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol, and are clear and appropriate. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate were noted. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report* *August 2019 QIC Minutes*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •SPH Analytics, as a vendor, provides a full report of process and results that meet the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 18% (n=446 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, but the NCQA target response rate was not met.
7.4	What conclusions are drawn from the survey data?	For Child CAHPS, key topics were Care Coordination (Care Coordination Composite) and Got Information of Help Needed. Documentation: *CAHPS Workbook*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2019 CAHPS® Child Medicaid Survey Summary Report*

CCME EQR Survey Validation Worksheet

Plan Name	**ABSOLUTE TOTAL CARE**
Survey Validated	**CAHPS MEDICAID CHILD CCC 5.0H**
Validation Period	2019
Review Performed	2020

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. (V2 updated based on September 2012 version of EQR protocol 5)

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

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 statement of purpose was documented. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	The study objectives were clearly documented. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Intended audience was identified and documented. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*

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

Survey Element		Element Met / Not Met	Comments And Documentation
2.1	Assess whether the survey instrument was tested and found reliable (i.e. use of industry experts and/or focus groups).	**MET**	Reliability of the survey was documented. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
2.2	Assess whether the survey instrument was tested and found valid. (Correlation coefficients equal to or better than 0.70 for a test/retest comparison).	**MET**	Validity of the survey and responses were documented. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*

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**	Definition of the study population was clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
3.2	Review that the specifications for the sample frame were clearly defined and appropriate.	**MET**	Specifications for sample frame were clearly defined. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
3.3	Review that the sampling strategy (simple random, stratified random, nonprobability) was appropriate.	**MET**	The sampling strategy was appropriate. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
3.4	Review whether the sample size is sufficient for the intended use of the survey. Include: Acceptable margin of error Level of certainty required	**MET**	The required sample size is 1,350 according to NCQA. ATC had a sample size of 3,466. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	**MET**	Appropriate procedures were used to select the sample. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*

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 raw and adjusted response rates to make sure they are clear and appropriate.	**MET**	Specifications for calculating raw and adjusted response rates were aligned with NCQA protocol and are clear and appropriate. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
4.2	Assess the response rate, potential sources of nonresponse and bias, and implications of the response rate for the generalize ability of survey findings.	**MET**	Response rate was evaluated, and implications of response rate were noted. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report* *August 2019 QIC Minutes*

ACTIVITY 5: REVIEW THE SURVEY IMPLEMENTATION

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 survey data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	A Quality Assurance Plan was in place. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the planned approach. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
5.3	Were confidentiality procedures followed?	**MET**	Confidentiality procedures were followed. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 6: REVIEW SURVEY DATA ANALYSIS AND FINDINGS / CONCLUSIONS

Survey Element		Element Met / Not Met	Comments And Documentation
6.1	Was the survey data analyzed?	**MET**	Data were analyzed. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate statistical tests were conducted. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Survey conclusions were supported by findings. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*

ACTIVITY 7: DOCUMENT THE EVALUATION OF SURVEY

Results Elements		Validation Comments And Conclusions
7.1	Identify the technical strengths of the survey and its documentation.	•The use of a CAHPS certified vendor allows for a standardized and audited approach to the implementation and analysis of the surveys. •Morpace, as a vendor, provides a full report of process and results that meet the necessary requirements and expectations of a survey report.
7.2	Identify the technical weaknesses of the survey and its documentation.	No technical weaknesses were noted in the review.
7.3	Do the survey findings have any limitations or problems with generalization of the results?	The overall response rate was 18% (n=636 valid surveys). The target response rate according to NCQA is 40.0%. The target number of valid surveys (n=411) was met, but the NCQA target response rate was not met.
7.4	What conclusions are drawn from the survey data?	For Child with CCC CAHPS, key topic was “Treated You With courtesy and respect (Customer Service Composite). Documentation: *CAHPS Workbook*
7.5	Assessment of access, quality, and/or timeliness of healthcare furnished to beneficiaries by the MCO (if not done as part of the original survey report by the plan).	Assessment of access, quality, and timeliness was encompassed in the results of CAHPS survey. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*
7.6	Comparative information about all MCOs (as appropriate).	Comparative information was provided and documented. Documentation: *SPH Analytics 2019 CAHPS® Child CCC Medicaid Survey Summary Report*

D. Attachment 4: Tabular Spreadsheet

CCME MCO Data Collection Tool

Plan Name:	**Absolute Total Care**
Collection Date:	2019

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					Policies are organized by department or functional area within the organization and are reviewed annually. The RSA Archer® system is used for policy storage and management. This system prompts the policy manager 60 days in advance of the due date for annual policy review. After the annual policy review (and revision as needed), final approval is granted by the Compliance Department. Staff are informed monthly via email of new and revised policies.
I B. Organizational Chart / Staffing						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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:						CCME's review of ATC's organizational chart and discussion during the onsite visit determined adequate staffing is in place to ensure all health care products and services required by the State of South Carolina are provided to members. Onsite discussion confirmed several positions indicated as vacant on the organizational chart have been closed or placed on hold.
1.1 *Administrator (CEO, COO, Executive Director);	X					ATC's President & CEO is John McClellan.
1.2 Chief Financial Officer (CFO);	X					Rodney Gaw, Vice President, Finance is ATC's Chief Financial Officer.
1.3 * Contract Account Manager;	X					Tracy Roakes continues to serve as the Contract Account Manager.
1.4 Information Systems personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Cynthia Jones is Senior Director, Claims Operations and Larry Barr oversees encounter data.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Vice President, Medical Management is Kathy Buchta. Natalie Crumpton is Director of Utilization Management.
1.5.1 Pharmacy Director,	X					The Senior Director, Pharmacy is Jenna Meisner. She is licensed as a pharmacist by the South Carolina Board of Pharmacy.
1.5.2 Utilization Review Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Joyce McElwain is the Senior Vice President, Quality Improvement. Sherry Jowers is the Supervisor, Quality Improvement.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Manager, Provider Relations position is vacant on the organizational chart. As discussed during the onsite visit, ATC anticipates filling this position. In the interim, Jennifer Marchant, Senior Director, Business Operations is fulfilling the responsibilities of this position.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					Kahlil Addison is the Manager, Customer Service for the Medicaid and MMP lines of business.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					William Logan, MD is Chief Medical Director and Conrad Manayan, DO is Medical Director. Both are licensed by the South Carolina Board of Medical Examiners.
1.10 *Compliance Officer;	X					Talvin Herbert is Vice President, Compliance and serves as ATC's Compliance Officer.
1.10.1 Program Integrity Coordinator;	X					Regina Moore serves as Program Integrity Coordinator.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10.2 Compliance /Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					Lee Jernigan, Director, Case Management is ATC's Interagency Liaison.
1.12 Legal Staff;	X					
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Frank Shelp is a board-certified Psychiatrist licensed by the South Carolina Board of Medical Examiners.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems						
1. The MCO processes provider claims in an accurate and timely fashion.	X					ATC's Information Systems Capabilities Assessment (ISCA) documentation indicates processes are in place to ensure payment results meet the requirements of the *SCDHHS Contract*. ATC only reported percentages for 30 days (98.6%) which exceeds the contractual 30-day requirement and is only 0.4% away from meeting the 90-day requirement.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					ISCA documentation states ATC's infrastructure is capable of receiving electronic files. ATC's compliance systems verify that electronic claim data is HIPAA compliant.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					ATC processes enrollment data every 24 hours. Additionally, the MCO uses the state health plan

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member ID# (based on Medicaid ID on the 834 file) to uniquely identify each enrollee. Finally, ATC runs reports to assist in identifying any duplicate members. Confirmed duplicates are merged in ATC's system and both Medicaid IDs are retained for the member.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					The ISCA materials provided indicate ATC is capable of creating HEDIS or HEDIS-like reports specified by HIPAA and SCDHHS.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ISCA documentation indicates ATC is able to adhere to the security and access management requirements of the SCDHHS Contract. A recent third-party audit of ATC's data processing systems and facilities confirms ATC's documentation. There were no high-risk exceptions identified in the audit report, and low risk exceptions were mitigated by compensating system controls and noted as being corrected.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					ATC has policies and procedures in place to address system security. The submitted documentation includes policies and procedures that conform to data protection standards required by HIPAA. Additional documentation was provided defining the organization's security requirements for its data processing systems.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					ATC had disaster recovery and business continuity plans in place to provide data protection and availability. The ISCA documentation included the results of a recent test of ATC's disaster recovery plan. The test results indicate the recovery exercise was successful, but there were areas of improvement. Included within the report were activities to revise the items in need of improvement.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The *Compliance and Ethics Program Description 2019-2020* (Compliance Plan) documents methods to ensure compliance with laws, regulations, and ethical conduct for employees. A separate *Fraud, Waste and Abuse Plan* (FWA Plan) describes processes to prevent, detect, and respond to incidents of potential or actual fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					Any issues identified are addressed in the standards below:
2.1 Standards of conduct;						The *Employee Handbook* provides an overview of expectations for employee conduct. It states a *Business Ethics and Code of Conduct* (Code of Conduct) is available on ATC's intranet and staff must review the Code of Conduct, sign an acknowledgement, and participate in annual Compliance training.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan describes the roles and responsibilities of the Compliance Officer and Program Integrity Coordinator.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						The Compliance Plan states standards and procedures are communicated to all employees, subcontractors, Board of Directors, and others through mandatory training programs or by disseminating publications that explain specific requirements, including information about the Compliance Program, identifying and reporting FWA, the Code of Conduct, privacy and confidentiality, and other related policies, procedures, and standards. Training is conducted for staff upon hire, annually, and as needed. The Compliance Officer and Human Resources Department track attendance and maintain records of employee training. Members of the Board of Directors must acknowledge receipt of, and agreement to comply with, the Code of Conduct. Policy CC.COMP.10, Annual Compliance Training and Policy SC.COMP.15, Compliance Training

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						provide additional procedural information about Compliance training. The Compliance Plan, page 7, states training on identifying and reporting FWA is provided to contracted providers as necessary or upon request. However, Attachment A of Policy SC.PRVR.13, Provider Orientations indicates FWA training is a core element of provider orientation. *Recommendation: Revise page 7 of the Compliance Plan to reflect that new provider orientation includes training on identifying and reporting FWA.*
2.6 Lines of communication;						The Compliance Department communicates with staff via e-mail, memoranda, newsletters, and other avenues. Staff are encouraged to obtain clarification of any confusion or questions about company policies or procedures, etc. from the Compliance Department. Staff are encouraged to report problems or concerns to supervisors, managers, the Compliance Officer, the ATC Senior Leadership team, or the corporate Compliance Officer. Staff are required to report all suspected and confirmed incidents of FWA, illegal acts, inappropriate disclosures, and other incidents to management or the Compliance Officer.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Alternately, the Ethics and Compliance Helpline and the Fraud, Waste, and Abuse Helpline may also be used and allow anonymous reporting. Information about reporting suspected or known Compliance and Program Integrity violations is included in Policy CC.COMP.03, Speaking Up: Reporting concerns, policy violations, misconduct and non-compliance. Policy CC.COMP.05, Prohibiting Retaliation Against Employees, Individuals, or Others and Policy CC.COMP.14, Whistleblower Policy provide information about prohibition of retaliation against employees for reporting violations.
2.7 Enforcement and accessibility;						ATC's *Employee Handbook* provides an overview of disciplinary guidelines for violations of compliance, conduct, or program integrity expectations and requirements. Disciplinary actions may include a performance improvement plan, warning, last-chance agreement, and employment termination. The level and type of disciplinary action will be based on facts and situational circumstances and may include consideration of prior infractions.
2.8 Internal monitoring and auditing;						Internal monitoring and auditing include but are not limited to annual contract assessments, functional area audits as needed, and monitoring of grievance and appeals activities. A monthly risk report of all areas of operational non-compliance is distributed to senior management

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and the Corporate Compliance department. The Compliance Officer and other management staff take immediate steps to correct any identified risks or violations and to prevent them from recurring. In certain cases, ongoing monitoring or subsequent reviews will be implemented to ensure corrective actions have been implemented successfully. The corporate Internal Audit Department also monitors and audits health plan operations and functional departments. Policy CC.COMP.12, Compliance Issues Management, Reporting and Tracking defines requirements for reporting risks, issues, other performance deficiencies and non-compliances. The policy defines Criticality levels (Minimal, Low, Moderate, High, and Critical) for findings, depending on the risk exposure to the organization, and defines the reporting timeframe for each of the five levels. Policy CC.COMP.41, Compliance Auditing and Monitoring Program – Medicaid and Commercial/Marketplace outlines processes for monitoring and conducting audits to measure compliance and assist in process improvement. The policy states, “It is Centene’s expectation that each health plan have an auditing and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						monitoring program managed by the Compliance Department."
2.9 Response to offenses and corrective action;						All allegations or reasonable suspicions of noncompliance or other illegal or improper activities by employees, subcontractors, or providers are promptly investigated. If the investigation confirms a violation, the Compliance Officer takes immediate action to correct the problem and to prevent recurrence. Actions may include (but are not limited to) immediate referral to law enforcement authorities, imposition of corrective action plans, termination from ATC 's provider network, and reports to applicable state or federal authorities.
2.10 Data mining, analysis, and reporting;						Monitoring and periodic audits of provider claims for compliance with established billing practices, regulations, and payor requirements are conducted. Centene's Special Investigation Unit staff and data systems mine claims data to detect billing irregularities and other fraudulent or abusive billing practices. Targeted providers include those identified with billing irregularities. A focus is placed on identified risk areas and areas of known prevalent fraudulent billing practices. Auditing and detection mechanisms include periodic claims sampling, claims edits, post-processing review of claims, provider profiling and credentialing, quality control, utilization management procedures, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation review to assess appropriate billing practices. Additional information is included in Policy CC.COMP.16 - Fraud, Waste, and Abuse Plan.
2.11 Exclusion status monitoring.						The Compliance Plan states, "ATC will check federal and state exclusion, termination, suspension, prepayment and behavioral health action databases on a regular basis to determine whether providers have been sanctioned or lost their professional license due to Medicaid fraud". According to Policy CC.COMP.16, Fraud, Waste, and Abuse Plan, ATC conducts monthly searches to identify any exclusions and reinstatements that have taken place since the previous search. ATC confirms the identity and determines the status of any "Provider and/or Subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee" through routine checks of federal databases, including the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), System for Award Management (SAM), SC List of Excluded Providers, SC List of Providers Terminated for Cause, and any other databases as the Department or Secretary of Health and Human Services may prescribe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy CC.COMP.27, Ownership and Management Disclosure, states monthly checks are conducted of the OIG LEIE and SAM.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The Compliance Plan gives an overview of the Compliance Committee membership and describes the functions and composition of the Compliance Committee. The committee is chaired by the Compliance Officer and meets quarterly. Committee membership includes but is not limited to the Plan President & CEO, Vice President of Compliance and Regulatory Affairs, Vice President of Finance, Vice President of Medical Management, Vice President of Operations and/or Vice President of Network/Contracting and/or Vice President of Quality, and other board members or senior leadership personnel as necessary. The Charter of Absolute Total Care's Compliance Committee describes the committee's purpose, committee composition, meetings, quorum (three members), attendance requirements, duties, and responsibilities. The charter states the committee has "the authority to retain or obtain the advice of one or more consultants, auditors, independent legal counsel or other advisers."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME's review of committee minutes confirmed appropriate meeting frequency and the presence of a quorum at each meeting.
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					
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 SC.PHAR.06, Pharmacy Lock-In Program defines requirements for, and processes related to, ATC's Pharmacy Lock-in Program.
I E. Confidentiality						
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					ATC has developed policies to address requirements and processes to ensure confidentiality of members' personal and protected health information, training for staff, etc. The Notice of Privacy Practices (NPP) is provided to members at the time of enrollment and within 60 days of a material revision to the notice. The NPP is available in the Member Handbook and on the health plan's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy CC.COMP.10, Annual Compliance Training is a corporate policy that states, "The Workforce will be assigned training regarding the privacy and confidentiality of individual health information within two (2) days of their hire date." Policy SC.COMP.15, Compliance Training is the corresponding health plan policy, and states, "All required Compliance training modules will be completed prior to new employees accessing PHI or PII."

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					Policy CC.CRED 01, Practitioner Credentialing & Recredentialing discusses the process ATC uses for credentialing and re-credentialing practitioners. The South Carolina specific requirements are addressed in footnotes throughout the document

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and in Attachment J. According to the policy, ATC will completely process credentialing applications within 60 days of receipt of a completed application. It was unclear how ATC monitors their timeliness for processing applications. The event tracking sheets provided with each credentialing and recredentialing file were incomplete. Staff indicated the timeliness is monitored daily through their credentialing system. ATC conducts a quality review of credentialing and recredentialing files in accordance with Policy CC.CRED.11, Credentialing Program Quality and Complaint Monitoring.
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					ATC's Credentialing Committee, a standing subcommittee of the Quality Improvement Committee, is responsible for oversight and operating authority of the Credentialing Program and has final authority to approve or disapprove provider applications. The Credentialing Committee meets monthly or no less than 10 times a year and reports to the Quality Improvement Committee quarterly. The Chief Medical Director chairs the Credentialing Committee. Other voting members include four network providers whose specialties include pediatrics, surgery, and psychiatry.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A review of a sample of meeting minutes showed the committee met monthly and a quorum of voting members was present for each meeting.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Issues regarding the credentialing file review are discussed below.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;		X				None of the practitioner credentialing files (16) contained the date the SCDHHS Terminated for Cause List was queried. *Quality Improvement Plan: Ensure credentialing files contain proof of the SCDHHS Terminated for Cause List was queried.*
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Four credentialing files did not contain copies of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider indicated on the application that laboratory services were provided at locations where they currently practice. This was discussed during the onsite and ATC indicated some provider locations (2 files) were considered nonparticipating locations. Screen shots were provided indicating the locations were not entered in the Portico system. *Quality Improvement Plan: Ensure that a copy of the CLIA Certificate is obtained for all practice locations noted as providing laboratory services.*
3.1.16 Ownership Disclosure form.	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					Seven recredentialing files did not contain the date of the Credentialing Committee's decision. Other issues regarding the recredentialing files are discussed below. *Recommendation: Document the credentialing committee's decision and the date of that decision in each recredentialing file.*
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;		X				Three recredentialing files did not show evidence the SCDHHS Excluded Provider List was queried. *Quality Improvement Plan: Ensure recredentialing files contain proof that the SCDHHS Excluded Provider List was queried.*
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					One recredentialing file was missing the query of the Social Security Death Master File.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;		X				Seven recredentialing files did not contain copies of the Clinical Laboratory Improvement Amendment (CLIA) certificate even though the provider indicated on the application that laboratory services were provided at locations where they currently practice. *Quality Improvement Plan: Ensure that a copy of the CLIA Certificate is obtained for all practice locations noted as providing laboratory services.*
4.2.15 Ownership Disclosure form.	X					
4.3 Review of practitioner profiling activities.	X					*Policy CC.CRED.01, Practitioner Credentialing & Recredentialing* includes the process for verifying provider specific performance. Evidence of performance data consideration was included in all recredentialing files except one.
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					
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				The process for credentialing and recredentialing organizational providers is outlined in Policy CC.CRED.09, Organizational Assessment and Reassessment. Issues identified with the organizational credentialing files included: •One file did not contain a copy of the facility's CMS certification. The CMS certification provided was for a different facility.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•A copy of the facilities license was not provided for 2 facility files. •The SCDHHS Excluded Provider List query for one facility was more than a year old. •The date of verification for one facility's NPI number was missing. •The ownership disclosure form for one facility was not dated. *Quality Improvement Plan: Develop a plan to monitor the credentialing files for organizational providers to ensure all requirements are met.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					The process for ongoing monitoring for practitioner sanctions, exclusions, complaints, and quality issues between recredentialing cycles is addressed in *Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints*. Ongoing monitoring performed on a monthly basis is addressed on page two and three of the policy and indicates SCDHHS' Excluded Providers Listing is queried (footnote number two). However, the SCDHHS Providers Terminated for Cause list is not mentioned in the footnote. Attachment J includes the Terminated for Cause List. *Recommendation: Update Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints, footnote two, to include the SCDHHS Providers Terminated for Cause List as a required query.*
II B. Adequacy of the Provider Network						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					ATC's *Network Analysis* document confirms General, Family Medicine, Internal Medicine, and Pediatrics practitioners are measured against a standard of 1 provider within 30 miles. The most recent analysis conducted on December 10, 2019 indicates: •88.3% of members have access to general practitioners •100% of members have access to family medicine, internal medicine, and OB/GYN practitioners •99.9% of members have access to pediatrics providers Onsite discussion confirmed ATC has ongoing efforts in place to recruit additional general practitioners into its network to improve access in the affected counties.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.		X				Policy CC.PRVR.47, Evaluation of Practitioner Availability defines the mileage requirements for high-volume and high-impact specialists as one within 50 miles and 75 minutes or less drive time. ATC provided GEO Access Reports reflecting evaluation of network provider access for most

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Status 1 providers. CCME could not identify in submitted information that ATC measures geographic access for Rehabilitative Behavioral Health providers and Audiology Therapy providers. This information was requested from ATC during the onsite but was not provided. Because these provider types are listed as Status 1 providers in SCDHHS' *Policy and Procedure Guide for Managed Care Organizations*, they should be included in the Plan's geographic access evaluations. *Quality Improvement Plan: Ensure all Status 1 providers are included in evaluations of network adequacy.*
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy SC.CONT.02, Network Adequacy (page 5, item 19) states ATC "analyzes its network adequacy on a bi-annual basis by running Geo Access Maps for all contracted PCPs, Specialists, key ancillary services, and Hospitals. Analysis reports are submitted to the SCDHHS on a bi-annual basis as prescribed by the SCDHHS MCO Contract."
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					ATC assesses members' cultural, ethnic, racial, and linguistic needs annually and makes adjustments to the provider network as necessary based in results of this assessment. The *2019 Cultural Competency Plan Description* states ATC "provides information to contracted

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers of cultural competency via the provider manual and website." CCME confirmed the information is available in the two resources.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.	X					ATC maintains an online, searchable provider directory that is updated daily and meets contractual requirements. Customer Service staff print and mail a hard copy to members upon request.
3.Practitioner Accessibility						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy SC.QI.05, Evaluation of the Accessibility of Services describes ATC's processes to monitor member access to primary care providers, behavioral health providers, and high volume/high impact specialists. ATC measures appointment access standards for PCPs and specialty referrals annually. It was noted in the *Practitioner Access Analysis 01/01/2018 to 12/30/2018* report that to goal for most standards for PCPs and specialty referrals was set at 90%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Three of four standards for PCPs and one of two standards for specialty referrals exceeded the 90% goal. *Recommendation: Consider increasing the goals for appointment access for PCPs and specialty providers.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the Annual EQR process for ATC, CCME conducted a provider access study focused on primary care providers. ATC gave CCME a list of current providers, from which a population of 3,196 unique PCPs was found. A sample of 289 providers was randomly selected from the total population for the access study. Attempts were made to contact these providers to ask a series of questions regarding access that members have with contracted providers. In reference to the results of the Telephone Provider Access Study, conducted by CCME, calls were successfully answered 71% of the time (172 of 243) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's results of 60%, this year's study had a statistically significant increase in successful calls at 71% (p=.0173), an increase of 11%. Results of the study are as follows: •For the 71 calls not answered successfully, 28 (39%) were because the call was not answered, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						15 (21%) were due to a wrong or disconnected phone number. •A total of 104 providers answered the question, "Do you accept Absolute Total Care?" Of the 104, 95 (91%) said that they do accept ATC. •A total of 91 providers responded to a question regarding accepting new Medicaid patients. Of the 91, 68 (75%) said they are accepting new Medicaid patients. •Of 48 providers that responded to a question about prescreening for new patients, 28 (58%) indicated they do have prescreening requirements. •Of the 28 providers with prescreening requirements, 23 (82%) require an application and a medical record review, and 5 (18%) require another form of prescreen such as ID, Insurance Card, and other information.
II C. Provider Education						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					The Provider Relations staff conducts orientation and training for new providers within 30 calendar days of active status.
2. Initial provider education includes:						Policy SC. PRVR.13, Provider Orientations with accompanying Attachment A: Provider Orientations Core Elements, Attachment B: Provider Orientation Materials, and the Medicaid Orientation Presentation are used during orientation sessions for providers and their office staff. Training topics

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						include, but are not limited to, health plan overview, Quality /HEDIS overview, managed care program and services, ATC's policies and procedures, and the Provider Manual. Specific comments are made below in sections 2.1-2.11.
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					Instructions for billing guidelines and processes are noted throughout the Provider Manual and on the website.
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					The Provider Manual informs providers of appointment availability standards and the requirement to provide or arrange for 24-hour coverage.
2.6 Recommended standards of care;	X					Clinical practice guidelines and standards of care are available on the website under the Quality Improvement Program section and on page 25 in the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Medical record handling, availability, retention and confidentiality;	X					Requirements for medical record review, documentation, and retention standards are outlined in the Provider Manual.
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					Pharmacy services and policies are described in the Provider Manual and an overview is discussed during orientation.
2.10 Reassignment of a member to another PCP;	X					Page 32 in the Provider Manual explains that providers must submit a written request to Member Services with supporting documentation in order to remove a member from their panel.
2.11 Medical record documentation requirements.	X					Policy SC.QI.13, Medical Record Review and the Provider Manual describe requirements for medical record documentation. Additionally, the Medical Records Documentation Standards can be found on the website.
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Policy SC22-HS-PR-001, SC.PRVR.14, Provider Visit Schedule/On-going Education describes regularly scheduled site visits from Provider/Network Relations Specialists as a method to providing on-going education. Additional education is accomplished through provider newsletters, faxes, or letters. Quarterly provider newsletters are posted on the website. Onsite discussion confirmed providers can call Provider Services to request information on available trainings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						ATC conducted town hall meetings in four regions within South Carolina in 2018.
II D. Primary and Secondary Preventive Health Guidelines						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC.QI.08, Clinical & Preventive Practice Guidelines states ATC adopts clinical and preventive practice guidelines for the provision of acute, chronic, and behavioral health services. The guidelines are updated as needed and approved by the Quality Improvement Committee at least every two years.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Preventive guidelines are addressed in the Provider Manual available on the website. ATC provides a hard copy upon request.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					ATC adopts clinical and preventive practice guidelines for the provision of acute, chronic, and behavioral health services relevant to the populations served as defined in Policy SC.QI.08, Clinical & Preventive Practice Guidelines. The guidelines are derived from recognized sources and are presented to the QIC for review, approval, and adoption.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					Current preventive and clinical practice guidelines are available on the ATC provider website and may be mailed to practitioners as part of disease management or other quality program initiatives.
II F. Continuity of Care						
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	X					Policy CC.QI.09, Continuity & Coordination of Medical Care and Policy CC.QI.10, Continuity & Coordination Between Medical and Behavioral Health Care describe how ATC monitors continuity and coordination of care for all members, between PCPs, specialists, medical and BH providers, ancillary providers, and pharmacy providers. The health plan collects data to assess, identify, and act on at least four opportunities to improve coordination of medical care and six opportunities for BH care as reported in the 2018 QI Evaluation.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Policy SC.QI.13, Medical Record Review describes ATC's processes for monitoring practitioner medical records for appropriate content and organization, ease of retrieval, and maintenance of confidentiality. ATC conducts medical record reviews at least annually for selected PCPs and may include high volume specialists.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual includes the information required to be included in medical records, as well as information about required medical record retention timeframes and maintaining records in a secure location to ensure confidentiality. The *Medical Record Documentation Standards* document is found on ATC's website.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Medical record documentation standards are included in Policy SC.QI.13, Medical Record Review, the Provider Manual, and on ATC's website. When comparing the *Medical Record Documentation Audit Tool* (Attachment A of Policy SC.QI.13) to the *Medical Record Documentation Standards* document found on ATC's website, CCME noted discrepancies. During onsite discussion, ATC staff indicated the document on the website is based on NCQA standards but the *Medical Record Documentation Audit Tool* used for the actual audits is compliant with standards required by the *SCDHHS Contract* and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations.* *Recommendation: Revise the Medical Record Documentation Standards document on the website to mirror the standard on the audit tool and to include only those standards for which providers are responsible for including in medical records.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					As stated in Policy SC.QI.13, medical record documentation review is conducted annually for selected PCPs and may include high volume specialists, such as OB/GYNs. Providers with audit scores below 80% are subject to corrective action and follow-up monitoring. The *Medicaid Medical Record Review 2019 Annual Audit Report* reveals 68 individual practitioners and a total of 340 medical records were audited. All 68 practitioners achieved passing scores of 80% or greater. The overall score for the 2019 audit year was 95%, representing a 1% decrease from the 2018 audit results of 96%. No corrective action plans were required.
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						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					ATC guarantees member rights and responsibilities as outlined in Policy SC.MBRS.25, Member Rights and Responsibilities. Members are informed of their rights in newsletters, on the website, and in the Member Handbook. Additionally, providers are notified of member rights and responsibilities in the *Medicaid Provider Manual 2019* and members can obtain information from Member Services Representatives.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in the Member Handbook, Provider Manual, and on the website.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 they be amended or corrected as specified in Federal regulation (45 CFR Part 164);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education						
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					Policy SC.ELIG.17, Enrollment says members will be issued a Welcome Packet and an ID card within 15 days of receiving enrollment data from SCDHHS. The welcome letter included with the Member Handbook provides instructions for selecting a PCP, using the ID Card, and contacting Member Services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additionally, page 50 of the Member Handbook reminds pregnant women that their baby will be covered by ATC from the date of birth.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						A table listing copayments and limits of coverage are in the Member Handbook, Provider Manual, and on the website. Copayments do not apply to children younger than 19 years old, pregnant women, or institutionalized individuals.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						The process and requirements for prior approval on medical, behavioral health, and pharmaceutical services is described in the Member Handbook. Services that require prior approval are indicated in the table of covered services under the "Limits" column. Additionally, services that require prior authorization are clearly listed throughout the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Manual. Prior approval is not required for family planning services, emergency visits, or BH.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The Member Handbook describes emergency care, post-stabilization care, and urgent care for physical, BH, or dental issues. 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;						
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						The Member Handbook describes processes and requirements for filing grievances and appeals that is easily identified under the heading "Member Grievance and Appeals." However, the grievance information on the member website is located under the heading of "Complaints and Appeals." This verbiage is inconsistent with the verbiage in the Member Handbook "Grievances and Appeals". Using different terms may prevent members from easily finding grievance information on the website. *Recommendation: Change the heading on the member website from "Complaints and Appeals" to "Grievances and Appeals" to be consistent with the verbiage in the Member Handbook.*
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The Member Handbook informs members to contact Customer Services or use the "Find a Provider Tool" on the website to select a PCP and obtain information on but not limited to, the PCP's gender, hospital affiliation, language spoken, and address.
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The toll-free telephone number and TTY number are provided in the Member Handbook. ATC's website supplies the mailing address, a phone directory, and offers an online "Contact Us" form for members 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;						
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						The Member Handbook and member website contain information on advance directives. Members are instructed to contact their PCP, an attorney, or the South Carolina Lieutenant Governor's Office on Aging to get assistance with the various kinds of advanced directives. The Provider Manual informs that each member over 18 years of age should receive information on living wills and advance directives.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					CCME did not identify where ATC notifies members of their right to request a copy of the Provider directory annually. During the onsite, ATC explained members were notified in the Healthy Moves Newsletter Issue 2-2019 via mail. However, page 4 in the newsletter states , "Call Member Services if you need a paper copy of your Member Handbook or anything else on our website." This statement does not specifically include the Provider Directory as required in the *SCDHHS Contract, Section 3.13.2.18.* Additional discussions revealed as of Q4 2019, member newsletters are available on the website only and will no longer be mailed unless requested. CCME advised the health plan to create a method where members are appropriately notified in writing of contractually required information or instructed how to access that information, as per the *SCDHHS Contract, Section 3.13.3.3.* *Recommendation: Ensure members are notified, at least once each calendar year, of their right to request a Member Handbook and Provider*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Directory as required in SCDHHS Contract, Section 3.13.2.18.
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					Policy SC.ELIG.14, Member Notification of Provider Termination states ATC notifies members in writing within 15 days after a receipt of a provider's termination from the network. CCME could not identify how the plan meets the requirement to notify members of changes in benefits at least 30 days before the effective date of a change, as required in the *SCDHHS Contract, Section 3.13*. During the onsite, ATC explained that mailings to head-of-households for all benefit changes are sent within the required timeframe, after it has been approved by DHHS. *Recommendation: Document the process used to inform members of benefit changes 30 days before the effective date, as required in the SCDHHS Contract, Section 3.13.*
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy SC.COMM.19, Member Materials Readability defines requirements for member program materials and states member materials are written no higher than a 6th grade reading level using the Flesch-Kincaid method to determine readability. Large-print materials are printed in a font size no smaller than 18-point.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME could not identify the font size used for regular print materials as required in the *SCDHHS Contract, Section 3.15.1.3*. During the onsite, ATC referenced Policy COMM.15, Request, Preparation, and Approval Process for Marketing and Communication Materials where 12-point font size is denoted for regular print member materials. *Recommendation: To ensure all requirements in SCDHHS Contract, Section 3.15.1.3. are captured, include cross-references in the respective policies for Policy SC.COMM.19, Member Materials Readability and Policy COMM.15 Request, Preparation, and Approval Process for Marketing and Communication Materials.*
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					The toll-free telephone number for Member Services and the 24-Hour Nurse Advice Line are located on the member's ID card, in the Member Handbook, and on ATC's website. Additionally, this information is located in education materials such as the member newsletter. The Member Services Call Center is staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of the normal business hours, the Interactive Voice Response system instructs to call 911 or go to the nearest emergency room for life-threatening emergencies. Callers are given the option to leave

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						a message to which a response is provided within one business day. The TTY number for the Member Services Call Center and the 24-hour Behavioral Crisis Hotline are published in the Member Handbook are made available for members. The Nurse Advice Line and the Behavioral Crisis Hotline are available to provide medical advice 24 hours a day via a toll-free telephone number. Member Services call center staffing, call monitoring, and service level requirements are defined in Policy SC.MBRS.28, Telephone Responsiveness and Call Center Performance, Policy CC.MBRS.09, Member Service Calls, and Policy CC.MSPS.24, Member & Provider Call Audit and Quality Criteria and Protocol.
III C. Member Enrollment and Disenrollment						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Policy SC.MBRS.02, PCP Change/Selection and page 13 of the Member Handbook describe the process for members to choose a PCP. Members can select one PCP for all members of the family or choose different PCPs as appropriate for their needs. ATC will assign a PCP if the member has not selected one within the required timeframe.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC.ELIG.11, MCO Initiated Disenrollment defines the process for ATC initiated disenrollment. ATC must request member disenrollment in writing to SCDHHS who is responsible for disenrollment actions to remove a member from the Plan.
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					Members are informed of scheduled preventative health services, available case management programs, and how to obtain educational support for medical, behavioral health, and pharmaceutical services on the website, Member Handbook, and via member newsletters. Health information is available for all members in various age groups. Incentives are offered for members to participate in the recommended services through the My Health Pays™ Rewards Program. During the onsite, CCME discussed the preventive health guidelines and recommendations on the website are located under the heading of "Quality Improvement Program" which is not readily accessible or easily recognizable to members. This observation was discussed during the 2018 EQR and a recommendation was made to address it at that time.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Place preventive health guidelines in a prominent location on the website to allow members to easily find them.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					The *EPSDT Program Description* explains that QI Outreach Teams conduct education and outreach, inform, track, and follow-up with members and providers to improve overall EPSDT screening rates and participation in the program. Members are encouraged and reminded to obtain these services through member mailings, phone calls, newsletters, and Care Gaps posted in the member portal. ATC identifies EPSDT-eligible members who are missing or due for services and sends periodicity letters to encourage them to obtain a health assessment and preventative care. The letters remind members about immunizations and screenings that are due and offers assistance in scheduling appointments and transportation for these services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					*The Upbeat* and *HealthyMoves* member newsletters provide a variety of information regarding wellness and prevention topics such as cancer screening and prevention, well visits, and diseases. The *2018 Quality Improvement Program Evaluation* describes how ATC uses outreach calls to inform members

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						about health risk factors and to encourage healthy behaviors. Onsite discussions revealed ATC conducts and participates in community events with established community partners to provide health and wellness information to members and the public.
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					Policy SSFB.01, Start Smart for Your Baby®: Program Overview describes how the corporate office identifies pregnant members to provide educational materials regarding their pregnancy, postpartum care, and newborn care, and offers an incentive to complete a required number of prenatal and postnatal visits.
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					ATC contracts with SPH Analytics, a certified CAHPS Survey vendor, to conduct the Child and Adult Surveys. Response rates for all three surveys decreased in comparison to the response rates in 2018. The Child CAHPS Survey response rate was 18% which decreased from last year's response rate of 22%. The Adult CAHPS Survey response rate was 17% which is a decrease from the 19% rate in 2018. The Children with Chronic Conditions (CCC) CAHPS Survey response rate was 18%, which is a decrease from last year's rate of 20%, and 17% for the general population, which is a decrease from last

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						year's rate of 19%. All response rates continue to fall below the National Committee for Quality Assurance target response rate of 40%. *Recommendation: Continue to implement and develop methods to increase awareness and importance of the survey to members, such as adding reminders to the call center, maximizing the oversampling to increase response rates, and text reminders.*
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The minutes from August 2019 QIC meeting and the CAHPS workbook document gives evidence of analysis, discussion, and initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					The 2019 CAHPS Survey results were reported to providers via the Issue 3 2019 Provider Newsletter.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					
III F. Grievances						
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.UM.11, Member Grievances defines ATC's processes and requirements for receiving, resolving, and responding to member grievances.
1.1 The definition of a grievance and who may file a grievance;	X					The definitions of a grievance and information about who may file a grievance are found in Policy SC.UM.11, the Member Handbook, the Provider Manual, and on ATC's website.
1.2 Procedures for filing and handling a grievance;		X				The Member Handbook, page 44, and the Provider Manual, page 89, state members or their authorized representatives can request clinically-urgent grievance processing. Onsite discussion confirmed this is incorrect and that expedited grievance processing is strictly an internal process

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						followed when a need for expedited processing is identified. *Quality Improvement Plan: Revise the Member Handbook, page 44, and the Provider Manual, page 89, to remove the information indicating members and their authorized representatives may request clinically-urgent grievance processing and resolution.*
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					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					ATC retains grievance records for a minimum of 10 years and maintains a complete record of each grievance and all actions taken on a grievance, including routing and correspondence.
2. The MCO applies grievance policies and procedures as formulated.	X					CCME's review of grievance files found that grievance acknowledgements and resolutions were timely, and that appropriate internal referrals were made when potential quality of care issues were identified. In one grievance file, the documented resolution addressed that the provider, against whom the grievance was filed for balance billing, does not bill

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						out-of-state Medicaid and has financial assistance programs to assist with bill payment. However, onsite discussion revealed this member was not eligible with ATC on the date the services were provided to the member by the out-of-state provider. The resolution letter did not indicate that the member was not eligible with ATC on the date of service by the out-of-state provider. *Recommendation: Ensure grievance resolution letters contain full information so that members understand the resolution provided.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The Grievance and Appeals Coordinator tracks and reports grievances. Aggregate reports of member grievances are provided to the Compliance Officer monthly and reported to SCDHHS. A database is used to track grievances and ensure grievance resolution within the appropriate time frame. The *2019 Medicaid Work Plan Update Q3* states "All medical and behavioral health determinations, grievances, appeals and QOC's are tracked and trend and presented to the UM and or QIC committees quarterly". CCME's review of QIC and UMC meeting minutes confirmed ATC follows the reporting process as documented.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The *2019 Quality Assessment and Performance Improvement Program Description Medicaid* describes the program's structure, accountabilities, scope, goals and available resources. The program description is reviewed and updated at least annually.
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					The program description outlines the scope of the QI program that includes over and underutilization data collection and analysis.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, ATC develops a *QI Work Plan* to guide and monitor activities for the year. The health plan provided the *2018* and *2019 QI Work Plans*. Both work plans were complete and addressed the requirements.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					ATC's Board of Directors has the ultimate authority and accountability for the oversight of the QI Program. The Board has delegated the operating authority of the QI Program to the Quality Improvement Committee (QIC). The QIC provides oversight and directions in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						assessing the appropriateness of care and service delivery.
2. The composition of the QI Committee reflects the membership required by the contract.	X					ATC's Medical Director chairs the QIC and members include network practitioners specializing in pediatrics, OB/GYN, family medicine, internal medicine, and behavioral health. Other members include senior management and internal department staff. Per QI Program Description, the attendance requirement for the QIC is listed as 50% of meetings held. There were four voting members who did not meet this attendance requirement. *Recommendation: Recruit additional voting members for the Quality Improvement Committee.*
3. The QI Committee meets at regular quarterly intervals.	X					QIC meets no less than quarterly and a quorum is defined as a minimum of three voting members. A review of the minutes shows the QIC met at regular intervals. The required quorums were met for each meeting.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes are recorded for each meeting and document committee discussion points and decisions.
IV C. Performance Measures						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures".	X					ATC uses Inovalon, a certified software organization, for calculation of HEDIS rates. CCME found the measures met all requirements. Details of the validation of the performance measures can be found in the *CCME EQR Validation Worksheets, Attachment 3.*
IV D. Quality Improvement Projects						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two projects were submitted for validation. They included Postpartum Care and Provider Satisfaction.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Both PIPs received a score within the High Confidence Range. It was noted the rate decreased from baseline to follow-up for the Provider Satisfaction PIP. This was discussed during the onsite and ATC indicated a workgroup met to review and discuss the decrease in the rate. Additional training was provided to the provider relations and call center staff to cover areas of provider concerns. ATC also implemented the Interpreta application that allows network providers to receive real-time analysis of care gaps and will host semiannual regional meetings and quarterly meetings to strengthen and enhance the existing interventions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Details of the validation of the performance improvement projects can be found in the *CCME EQR Validation Worksheets, Attachment 3.* *Recommendation: Continue interventions such as workgroups and staff education to impact provider satisfaction.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Network providers participate through the Quality Improvement, Credentialing, and Peer Review Committees and provide valuable feedback through the provider experience survey.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Feedback is provided via newsletters, provider relations representatives, Provider Manuals, ATC's provider portal, and with office site visits. Provider reports cards, based on specific HEDIS measure results, are provided to high-volume providers annually.
IV F. Annual Evaluation of the Quality Improvement Program						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					ATC evaluated the QI Program and summarized the results of this evaluation in the *Quality Assessment and Performance Improvement Program Evaluation Medicaid - 2018*. Most of the program's objectives were met with areas not meeting the goals being

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						analyzed and any interventions needed to improve performance identified.
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					The *Utilization Management Program Description* outlines the goals, scope, staff roles for physical health, behavioral health (BH), and pharmaceutical services for members in South Carolina. Several policies, such as SC.UM.05, Timeliness of UM Decisions and Notifications and CC.UM.04, Appropriate UM Professionals provide guidance on

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						utilization management (UM) processes and requirements. In 2018, ATC delegated utilization management functions to two third-party delegates: one external vendor and one internal company. The external vendor, National Imaging Associates, provides radiology services. The internal company, Envolve Pharmacy Solutions, provides pharmaceutical management services.
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					Requirements for service authorization timeframes are correctly described in SC.UM.05, Timeliness of UM Decisions, the UM Program Description, the Member Handbook, and Provider Manual.
1.5 consideration of new technology;	X					Consideration of new technology and new uses of existing technologies are addressed in Policy CC.UM.02, Clinical Decision Criteria and Application and the UM Program Description.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					ATC has a Preferred Provider Designation Program as described in Policy SC.UM.54, Preferred Provider Designation. During the onsite, ATC staff explained there are no providers in the program and said they will reevaluate it for improvement opportunities.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The roles of the Medical Directors for physical and behavioral health are described in the UM Program Description. Responsibilities include, but are not limited to, supervising medical necessity decisions, conducting UM reviews, and participation on plan committees. Dr. William Logan is the Chief Medical Director and Dr. Frank Shelp is the BH Medical Director.
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					The UM Program Description and UM Program Evaluation are reviewed and approved by the Utilization Management Committee and/or Quality Improvement Committee annually. The UM Program Evaluation includes analysis of UM, CM, DM, and pharmacy resources, metrics, and key performance. The UM Program Description outlines the structure and processes of the Medical Management Department. The 2018 UM Program Evaluation and UM Program Description were presented and approved by the QIC on March 26, 2019.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy SC.UM.02, Clinical Decision Criteria and Application explains UM criteria are reviewed annually with participation of physician members of the QIC and updated as needed. QIC meeting minutes reflected review and approval of internal medical policy statements and InterQual criteria.
V B. Medical Necessity Determinations						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					The Utilization Management Program Description, and Policy CC.UM.02, Clinical Decision Criteria and Application lists InterQual criteria, ATC clinical policies, and evidenced-based criteria are used for determining medical necessity. Individual member circumstances and the local delivery system are considered when determining medical necessity.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM approval files reflect consistent decision-making using approved criteria and relevant medical information as described in the UM Program Description and CC.UM.02, Clinical Decision Criteria and Application.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The processes for covering hysterectomies, sterilizations, and abortions are described in Policy SC22-HS-UM-030, Hysterectomies, Sterilizations, and Abortions. The criteria for utilization are communicated in the Member Handbook, the Provider Manual, and on the website. The applicable

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						forms are correctly noted under the provider tab of the website.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					ATC allows for unique patient decisions in UM determinations, as noted in Policy CC.UM.02, Clinical Decision Criteria and Application, which describes how individual circumstances and clinical information pertaining to cases are reviewed and compared to the criteria. Additionally, page 12 of the *2019 UM Program Description states*, "Utilization review decisions are made in accordance with currently accepted medical or health care practices, while taking into consideration the individual member needs and complications at the time of the request…" Files reflect consideration of individual member's needs and requests to obtain additional information when applicable.
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					ATC conducts Interrater Reliability (IRR) testing to assess the consistency with which physician, non-physician, and clinical staff reviewers apply UM criteria as described in Policies CC.UM.02, Clinical Decision Criteria and Application and CC.UM.02.05, Interrater Reliability. The established benchmark is a minimum of 90% for each reviewer. The 2018 UM Program Evaluation

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reflect average IRR scores of >94% in several service categories. Additionally, Policy SC.PHAR.18, Clinical Pharmacy Services Inter-rater Reliability describes that ATC's Clinical Pharmacy Services Director annually conducts IRR testing for pharmacy coverage determinations using the NCQA "8/30" methodology with a goal to achieve 90% agreement between reviewer and rater.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.		X				Evolve Pharmacy Solutions is the pharmacy benefit manager for ATC. Pharmacy benefit information is available in Policy SC.PHAR.09, Pharmacy Program, Policy CC.PHAR.10, Preferred Drug List, the Member Handbook, the website, and the Provider Manual. The Preferred Drug List (PDL) provides formulary restrictions indicating medications that require prior authorization, limitations, or step therapy. The process for members to obtain over-the-counter medications are described in the Member Handbook. During the onsite, CCME discussed the following issues: •Policy CC.PHAR.10, Preferred Drug List, page 3, indicates that PDL changes are communicated annually and that Negative PDL changes are only communicated to the member and their provider.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						However, the timeframe and communication method in the policy are not consistent with ATC's processes. ATC staff confirmed that their process is to communicate PDL changes 30 days before the effective date and changes are posted on the website in addition to notifying the impacted member and provider. •Preferred Drug List Updates are posted on the website under the heading "Which Drugs Are Covered." This is not a prominent and easily accessible location for members to find PDL changes. •The Pharmacy Program Description, page 10, indicates ATC allows 30 days for new members to fill prescriptions that require prior authorization. However, the *SCDHHS Managed Care Organizations Policy and Procedure Guide, Section 4.2.21.3* states, "the new MCO is required to honor existing prescriptions needing a Prior Authorization (PA) under the new plan's formulary for a period of no less than ninety (90) days." ATC staff confirmed that they received permission from SCDHHS to authorize prescriptions for new members for 30 days and 60 days when appropriate. *Quality Improvement Plan: To be consistent with ATC's processes and with requirements in the SCDHHS Contract, Section 4.2.21.2.3, edit page 3 in Policy SC.PHAR.10, Preferred Drug List to reflect*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						that PDL changes are posted to the website 30 days before the intended effective date in addition to notifying the impacted member and provider. *Recommendation: Place the Preferred Drug List Updates document in a prominent and easily accessible location on the website, such as near the PDL document. Edit the ATC Pharmacy Program description, page 10, to indicate ATC will honor existing prescriptions needing a prior authorization under ATC's formulary for a period of no less than 90 days as noted in the SCDHHS Managed Care Organizations Policy and Procedure Guide, Section 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					Policies SC.PHAR.07, Specialty Pharmacy Program and SC.PHAR.01, 72-Hour Emergency Supply Of Medication describes ATC's process for approving medication while a prior authorization request is pending.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Policy SC.UM.12, Emergency Services, the Provider Manual, and the Member Handbook correctly describe emergency medical services and post-stabilization services and requirements.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					ATC has staff who are trained and licensed to conduct physical and behavioral health clinical reviews, as described in Policy CC.UM.04,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Appropriate UM Professionals. Policy CC.UM.02, Clinical Decision Criteria and Application, and the UM Program Description. Policy CC.PHAR.08, Pharmacy Prior Authorization and Medical Necessity Criteria indicates Certified Pharmacy Technicians or Clinical Pharmacists at Envolve Pharmacy Solutions conduct initial UM reviews. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Service authorization time frames for approval files are consistent with Policy SC.UM.05, Timeliness of UM Decisions and Notifications, the UM Program Description, and SCDHHS Contract requirements.
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					Overall, denial files reflect additional information is requested when necessary to complete service determinations. However, the denial notice in one file states, "The clinical information provided is extremely limited (no complete doctor's note) and does not meet criteria of Absolute Total Care's policy called CP.MP.84 Cell-free DNA testing or InterQual 2018.2 subset Cell-Free Fetal DNA testing (Custom) CCO." If it was warranted for the reviewer to document that the clinical notes were incomplete, there was no evidence that additional

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						clinical notes were requested before rendering a determination. *Recommendation: Ensure additional clinical information is requested when physician reviewers identify the submitted provider's notes are incomplete.*
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of files with adverse benefit determinations reflect decisions are made by appropriate physician specialists as outlined in Policy CC.UM.04, Appropriate UM Professionals. Physician specialties include internal medicine, emergency medicine, family practice, and behavioral health. The list of UM Physician reviewers shows a diversity of clinical specialties.
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 reflect denial decisions are made according to the processes described in Policy SC.UM.05, Timeliness of UM Decisions and Notifications. Adverse benefit determinations are promptly communicated via phone or fax and followed by a written letter. Adverse benefit determination notices are written clearly in language that is easily understood by a lay person and include the physician's rationale. Additionally, notices included correct information and instructions on the appeals processes and the process for a peer-to-peer discussion.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V C. Appeals						
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					Requirements and ATC's processes for receiving, reviewing, and resolving member appeals are documented in Policy SC.UM.13, Member Appeals. Information about appeals requirements and processes are included in the Member Handbook, Provider Manual, and on ATC's website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					Policy SC.UM.13, the Member Handbook, the Provider Manual, and ATC's website appropriately document the definitions of an adverse benefit determination and an appeal and who may file an appeal.
1.2 The procedure for filing an appeal;	X					Requirements for filing an appeal are documented in Policy SC.UM.13, the Member Handbook, the Provider Manual, on ATC's website, and in letter templates. Onsite discussion confirmed ATC requires members to submit a written appeal request following denial of expedited processing when the appeal was requested verbally. However, this requirement is not included in the Member Handbook, Provider Manual, or in the Expedited Appeal Denial letter template. Regarding a member request to review the case file and other documents related to an appeal, ATC staff confirmed that the information would be supplied to the member via certified mail. However, the Appeal

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Acknowledgement letter template does not indicate that the information will be provided to the member by mail. The letter template states, "If you want to come in and look at your file, please call us." This language could be interpreted to mean that the member must come to ATC to view the material. *Recommendation: Revise the Member Handbook, Provider Manual, and Expedited Appeal Denial letter template to include the requirement that a written appeal request is required following the denial of expedited processing when the appeal was requested verbally.* *Revise the Appeal Acknowledgement letter template to clearly indicate how members can view the case file and other documents related to an appeal.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy SC.UM.13, Member Appeals defines elements required for appeal resolution letters. CCME's review of the Appeal Resolution letter template (for resolutions to uphold the initial denial) found it includes appropriate information regarding requesting a State Fair Hearing. The "Filing an Appeal" page on ATC's website contains conflicting information about requesting a State Fair Hearing. Under the heading "Member Rights to State Fair Hearing" it correctly states members must request a State Fair Hearing in writing. However, under the heading "What if I am still not satisfied?" on the same page it states "…you can ask for a State Fair Hearing with SCDHHS by contacting the Division of Appeals and Hearings at 803-898-2600." *Recommendation: Clarify the website to clearly convey that all requests for State Fair Hearings must be requested in writing.*
1.7 Other requirements as specified in the contract.	X					All requirements for continuation of benefits are included in Policy SC.UM.13, the Member Handbook, and the Provider Manual. Sufficient information is included in the initial denial letter template and appeal uphold letter template.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO applies the appeal policies and procedures as formulated.	X					CCME's review of appeals files confirmed staff follow appropriate processes for receiving, reviewing, and resolving appeals.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					According to Policy SC.UM.13, Member Appeals, "Records of all appeals are maintained by Absolute Total Care and are reviewed by the Quality Improvement Department to identify trends and opportunities to improve quality of care and service." Appeals data is reported during UMC meetings and reviewed during QIC meetings. The QI Program Evaluation for 2018 includes a quantitative analysis and qualitative analysis of appeals data and indicates barriers/issues identified and plans to address those.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					The *2019 Care Management Program Description* and Policy CC.CM.11, Disease Management Programs describes ATC's approach to care management (CM) and disease management (DM).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO has processes to identify members who may benefit from case management.	X					The Care Management Program Description describes the methods by which eligible members are identified and referred into care management, such as medical, behavioral health and pharmacy data, health risk assessment results, and from internal or external referrals. Policy CC.CM.06, Predictive Modeling Methodology explains ATC uses a predictive modeling and care management analytics tool to identify and stratify members for disease and case management services.
3. The MCO provides care management activities based on the member's risk stratification.	X					ATC's approach to member engagement is outlined in Policy SC.CM.02, Care Coordination/Care Management Services. It describes in detail the CM services provided to members in each stratification level: low risk, moderate risk, and high risk
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					ATC utilizes an integrated care management team approach that includes BH and physical health CM where the member's primary diagnosis determines whether the lead CM is a physical or BH coordinator.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					At the onsite, ATC reported the Transition Coordinator is Lee Jernigan.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The 2018 *Quality Assessment and Performance Improvement Evaluation* and the *2018 Case Management Member Satisfaction Analysis* describe how ATC measures performance of the CM program annually. Members actively enrolled in CM for at least 60 days are contacted via email or telephone and asked to complete a CM satisfaction survey. ATC established a goal of 90% for overall CM satisfaction. The quality and effectiveness of the program and the information obtained is used to assess strengths, weaknesses, and develop recommendations for improvement of the CM and DM Programs. Reporting and recommendations were presented to the Quality Improvement Committee on April 20, 2019 and were approved.
7. Care management and coordination activities are conducted as required.	X					Sampled files indicate CM activities are conducted as required and Care Managers follow policies to conduct the appropriate level of case management. HIPAA verification and identifying care-gaps are consistently addressed.
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 under-utilization and over-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for under and over utilization.	X					ATC analyzed and monitored data for several services regarding utilization and offered recommendations based on findings in the committee meetings and in the program evaluations. From a population health perspective, member readmission and length-of-stay (LOS) may be impacted by certain diseases. *Recommendation: Conduct analysis to determine if a performance improvement project, that focuses on diseases related to length-of-stay or readmissions, is warranted. Consider how factors such as care coordination or adherence impact length-of-stay and member readmissions.*

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION						
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					ATC delegates credentialing to several organizations. Policy CC.CRED.12, Oversight of Delegated Credentialing provides the process the Plan follows to evaluate and monitor the delegated entity's capacity to perform the delegated activities. A pre-delegation review is completed prior to the activation of a delegation agreement. In addition to delegated credentialing, other health plan functions are delegated. Policies for pre-delegation assessment, ongoing monitoring, and annual oversight are documented in Policy SC.COMP.14, Oversight of Delegated Vendors and Policy SC.UM.18, Oversight of Delegated Utilization Management. ATC provided sample copies of credentialing and non-credentialing delegation agreements.
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					Pre-delegation and annual oversight monitoring were provided for all delegated entities. Deficiencies identified during the monitoring required the entity to complete a corrective action plan. The monitoring report and the oversight letter indicated follow-up for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the corrective action items would not occur until the next annual monitoring. *Recommendation: ATC should follow-up on the deficiencies identified during pre-delegation and annual oversight monitoring before the next annual monitoring is conducted.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII STATE-MANDATED SERVICES						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					ATC ensures pediatric immunization requirements are monitored by instructing providers to bill appropriate vaccine codes, as described on page 48 of the Provider Manual. Additionally, providers are informed that ATC monitors compliance with immunization requirements by reviewing PCP immunization rates through Healthcare Effectiveness Data and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Information Set (HEDIS) medical record reviews conducted by a vendor. HEDIS reports in the *2018 Quality Assessment and Performance Improvement Program Evaluation* details how child and adolescent immunizations are tracked, monitored, and evaluated for improvement opportunities.
1.2 performing EPSDTs/Well Care.	X					ATC uses several methods to ensure EPSDT requirements are tracked, such as listing billing requirements for EPSDT services in the Provider Manual and conducting annual medical record reviews. The *EPSDT Program Description*, located on the provider website, explains ATC follows the EPSDT periodicity schedule according to the American Academy of Pediatrics and providers are informed of impending or missed EPSDT services by receiving a member non-compliant list. Provider compliance with providing EPSDT services is monitored through random medical record reviews.
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					