Constellation Quality Health

Absolute Total Care

2024 External Quality Review

Submitted: January 9, 2025

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 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 2024 External Quality Review (EQR) that Constellation Quality Health (Constellation) 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 2023 Annual Review.

The goals and objectives of the review are to:

- Determine if the health plan is following service delivery as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2023 Annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered and are of good quality.

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

Summary and Overall Findings

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

- Disenrollment Requirements and Limitations (*§ 438.56*)
- Enrollee Rights Requirements *(§ 438.100*)
- Emergency and Post-Stabilization Services *(§ 438.114)*
- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*

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

To assess ATC's compliance with the 14 *Subpart D* and QAPI standards as related to quality, timeliness, and access to care, Constellation's review was divided into seven areas. Those areas included:

- Administration
- Provider Services
- Member Services
- Quality Improvement
- Utilization Management
- Delegation
- Mental Health Parity

The following is a high-level summary of the review results for those areas. Additional information regarding the reviews, including strengths, weaknesses, and recommendations are included in the narrative of this report.

Administration

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

ATC develops and implements policies to guide staff in core business processes, facilitate operations, and ensure compliance with laws and regulations. Policies are reviewed at least annually and when there are changes in laws, regulations, etc. Policy CC.COMP.22, Policy Management, outlines the processes for policy development and approval; however, it did not include information regarding committee involvement in policy review and approval.

ATC's staffing is sufficient to conduct all required activities and to provide the required services. All required key positions are filled. The Organizational Chart depicts reporting relationships and is color-coded to indicate key positions, temporary/contingent personnel, and vacant positions. ATC submitted a Key Personnel list which indicates 62 of the total 114 Full Time Equivalents (FTEs) for case management staff are in-state. The *SCDHHS Contract, Section 2.2.2, Exhibit 2*, requires all case management staff to be in-state.

The Compliance and Ethics Program Description 2024-2025, the Fraud, Waste and Abuse Plan, and the 2024 Code of Conduct provide information about compliance with laws and regulations; processes to detect, prevent, and respond to fraud, waste, and abuse; and expectations for appropriate and ethical business conduct. Associated policies and procedures provide additional, detailed information about compliance and fraud, waste, and abuse (FWA) detection and prevention activities.

ATC outlines the roles and responsibilities of the Compliance Officer and Program Integrity Coordinator in the Compliance and Ethics Program Description 2024-2025 (Compliance Plan). The Compliance Plan and the South Carolina Market Compliance Committee Charter provide information about ATC's Compliance Committee, including the committee's purpose, functions, membership, committee chair, meeting frequency, etc. Compliance Committee meeting minutes for February 2024 through November 2024 confirmed the committee met at the defined frequency with the required quorum present and reflected detailed discussion of the agenda topics.

Compliance training is mandatory for all employees upon employment and annually. The training covers the Compliance Program, FWA identification, reporting mechanisms, the Code of Conduct, privacy and confidentiality, etc. Employees are required to report violations of laws and company policies, illegal acts, inappropriate disclosures, and incidents of FWA. ATC educates staff about the internal avenues available to report or discuss concerns and provides additional options that allow anonymous reporting and are available 24 hours per day. ATC protects employees from retaliation for reporting compliance and FWA concerns.

ATC's Pharmacy Lock-in Program aims to ensure appropriate utilization of prescription medications and medical services. Processes and requirements for the program are documented in policy and are compliant with contractual requirements.

ATC's Information Systems Capability Assessment documentation indicates that ATC is capable of fulfilling the requirements of the *SCDHHS Contract*. Specifically, the organization's policies adhere to industry and regulatory best practices and are reviewed and updated regularly. Additionally, all staff are required to undergo security awareness training, and role-based security training is required on an annual basis. ATC has a robust disaster recovery infrastructure and conducts frequent disaster recovery testing, demonstrating the priority on availability. ATC processes 99% of clean claims within 30 days and 100% of all claims within 90 days.

Provider Services

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

Credentialing and recredentialing processes are documented in the Credentialing and Recredentialing Program Description and in policies that are specific to practitioner and organizational provider credentialing and recredentialing. ATC implemented the quality improvement plan from the previous EQR related to the timeframe for processing credentialing applications for organizational providers. The initial credentialing files for practitioners and the initial credentialing and recredentialing files for organizational providers were compliant with all requirements and no issues were identified. Two issues were noted in the practitioner recredentialing files; however, these were isolated to one file each and were related to verification timeframes for Drug Enforcement Agency certification and querying the South Carolina Terminated for Cause list.

The Credentialing Committee is chaired by the Chief Medical Director, meets monthly, and uses a peer-review process to make credentialing decisions. Committee members have a variety of specialties including pediatrics, anesthesiology, family medicine, internal medicine, psychiatry, and emergency medicine. The review found that the Credentialing Committee meeting template incorrectly documents the requirement for a quorum and therefore, one meeting did not have a quorum when credentialing decisions were made.

ATC has appropriate processes in place for initial and ongoing provider education, with training provided in-person or virtually. New provider orientation is conducted within 30 business days of the provider becoming active in ATC's network. The 2024 Medicaid Provider Manual (Provider Manual) is an additional source of information for network providers, but it does not provide information about benefits for communicable disease services and post-stabilization services.

Providers are educated about clinical practice and preventive health guidelines and are encouraged to use the guidelines to assist in developing personalized treatment plans for members. ATC measures compliance with the guidelines through Healthcare Effectiveness Data and Information Set (HEDIS®) measure monitoring and medical record audits. The hyperlink to one guideline on ATC's website was non-functional. Providers are also educated about medical record documentation standards and monitored for compliance through medical record audits. The Medicaid Medical Record Review 2024 Annual Audit Report indicated 355 records were audited across 71 practitioners and all received passing scores.

Network Adequacy Validation: Constellation conducted a validation review of ATC's provider network following the CMS protocol titled, *EQR Protocol 4: Validation of Network Adequacy*. ATC's provider network was found to be adequate and consistent with the requirements of the CMS protocol. Geographic access standards for all provider types are appropriately documented in policy, confirming that ATC implemented the quality improvement plan from the previous year to include the geographic access standards for primary care providers and specialty care providers in its policy. ATC evaluates the geographic adequacy of its network and monitors network

adequacy reports, weekly Geo Access mapping, member satisfaction survey results, and complaint and grievance data regarding satisfaction with practitioner availability. Documentation confirmed goals were met for geographic access to all Status 1 providers and that ATC contracts with all required Status 2 provider types. If network gaps are identified, ATC implements both short-term and long-term interventions to resolve the gaps and ensure members are able to get the needed care. No issues were noted with ATC's online Provider Directory ("Find a Provider" tool). The PDF 2024 Provider & Pharmacy Directory did not include practice names/group affiliations and age groups as required by the *SCDHHS Contract, Section 3.12.3.1.1*. Appointment access standards are documented in a policy, the Provider Manual, the Medicaid Member Handbook (Member Handbook), and the Absolute Total Care & Wellcare New Provider Orientation document. For specialty emergent visits, the timeframe documented in the Provider Manual, Member Handbook, and the New Provider Orientation document is inconsistent with the requirement stated in the *SCDHHS Contract, Section 6.2.3.1.5*. ATC's 2024 Accessibility of Services Report indicates an audit was conducted by a vendor in Q2 2023. Goals were met for all appointment categories except for primary care physician (PCP) after-hours access and obstetrics/gynecology (OB/GYN) urgent care. Identified barriers and interventions to address the barriers were documented.

ATC conducts annual assessments of the cultural, ethnic, racial, and linguistic needs of members to determine if the provider network can meet those needs. Cultural competency information is included in the Provider Manual and resources are available on ATC's website.

For the Telephone Provider Access Study conducted by Constellation, the successful contact rate was 61%, a non-significant decline in the successful contact rate from the previous year's study.

Member Services

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

The review of Member Services includes member rights, member education, enrollment and disenrollment processes, member satisfaction surveys, processes for handling grievances, and a grievance file review. Members are informed of their rights and responsibilities, and the list of member rights is consistently documented across the Member Handbook, the Provider Manual, and on ATC's website.

Covered and excluded services are outlined in the benefit grid listed in the Member Handbook. However, during the onsite, it was discussed that the Member Handbook does not contain information regarding the specific services provided through the Developmental Evaluation Centers (DECs) that became effective on 2/1/24.

Members are informed in the Member Handbook that they will receive notice of significant changes in the benefits package at least 30 days before the intended effective date of the

change. Members are also informed that notification will be provided if their PCP terminates from the network. Processes for notifying members of provider terminations were addressed in policy; however, ATC staff confirmed there is no policy that defines processes for notifying members of changes in the benefit package.

ATC maintains a call center that is available via a toll-free telephone number from 8:00 a.m. to 6:00 p.m., Monday through Friday. Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, defines performance standards for speed of answer, average hold time, and the disconnect rate for incoming calls.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description 2024 includes the goals, objectives, and guidelines for the EPSDT Program. ATC uses various data sources to identify EPSDT eligible members, monitors compliance with the provision of EPSDT services, and conducts outreach to educate and follow-up with members to improve EPSDT screening rates. The Member Handbook describes available lifestyle management and chronic conditions programs. However, no information was included regarding how to access these programs.

ATC contracts with Press Ganey to conduct their member satisfaction surveys. The survey results are shared with providers. However, the member Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, while accessible on the website, were challenging to locate due to the document title not clearly indicating their presence. Constellation recommends enhancing accessibility by featuring the CAHPS results prominently in a newsletter, email, or fax blast, or placing the results in a more visible and user-friendly location on the website for providers.

The process for filing and processing grievances was found in policy, the Member Handbook, Provider Manual, and on the website. Steps for appointing an authorized representative, if needed, are provided. Appropriate timeframes are detailed in policy for grievance acknowledgement, extensions if needed, and resolution. Constellation reviewed a sample of grievance files and found that all were resolved within the 90-day timeframe. One grievance was not acknowledged in a timely manner and was closed with 67 days remaining due to missing information and member contact. During the onsite, it was recommended to review and revise processes and retrain staff to ensure consistent steps are taken for locating accurate contact information for members when additional information is needed to process a grievance.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

The 2024 Quality Program Description for ATC outlines the health plan's commitment to continuous quality improvement across all aspects of the organization. The program integrates

quality assurance, management, and improvement into daily operations, with defined performance metrics and accountability to the Quality Improvement Committee (QIC) and Board of Directors.

The Quality Work Plan is a key component of ATC's continuous quality improvement cycle. The Quality Work Plan is developed annually and reflects the ongoing progress of quality activities and includes recommendations for improvements based on the annual Program Evaluation. ATC provided the 2023 and 2024 Quality Improvement (QI) work plans. Both documents clearly define the activities completed or to be completed by each department and supporting committees throughout the year.

The QIC is the senior leadership committee, accountable to the Board of Directors, that reviews and monitors all clinical quality and service functions of the health plan. The QIC is composed of senior staff and physicians who are voting members, along with support staff. The Chief Medical Director chairs the committee. Membership includes network practitioners specializing in pediatrics, OB/GYN, psychiatry, and family medicine.

Providers receive information about their performance through several methods. ATC offers population health management reporting designed to support providers in delivering timely, efficient, and evidence-based care. This includes care gap reporting at member and population levels and exportable patient data to support member outreach. The Provider Analytics Tool supports providers participating in value-based programs by identifying performance opportunities and assisting with population health management initiatives. Providers may receive interventions to address performance that is out of range from their peers. This can include provider education, sharing of best practices, assistance with barrier analysis, development of corrective action plans, and ongoing medical record reviews.

Annually, ATC evaluates the effectiveness of the QI Program and reports the results to the Board of Directors. The 2023 Quality Improvement Program Evaluation included an assessment of the QI program's impact on improving clinical practices and member care, resource adequacy, a summary of completed and ongoing quality activities addressing clinical care and service quality, performance trends, interventions, and recommendations. The evaluation findings are used to refine the QI Program, ensuring continuous improvement and alignment with ATC's strategic goals and regulatory requirements.

Performance Measure Validation: ATC uses a certified software organization for calculation of HEDIS® rates. Rates were audited by Attest Health Care Advisors. The performance measure (PM) validation found that ATC was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c) and §457.1240 (b)*.

All relevant HEDIS performance measures for the current review year (2023) were compared to the previous year (2022) and the changes from 2022 to 2023 are reported in the Quality Improvement section of this report. The following table highlights the HEDIS measures found to have substantial increases or decreases in rate from 2022 to 2023. A substantial increase or decrease is a change in rate greater than 10%.

Table 1: HEDIS Measures with Substantial Changes in Rates

Measure/Data Element	Measure Year 2022	Measure Year 2023	Change from 2022 to 2023
Substantial Increase in Rate (>10% improvement)			
Blood Pressure Control for Patients With Diabetes (BPD)	56.69%	69.34%	12.65%
Kidney Health Evaluation for Patients With Diabetes (KED)	25.81%	36.04%	10.23%
Substantial Decrease in Rate (>10% decrease)			
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	75.34%	47.22%	-[+]28.12%

[+]Break in trending is recommended due to changes to the exclusion criteria.

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

ATC submitted three PIPs for validation. Topics included Hospital Readmissions, Timeliness of Prenatal Care, and Adult Access to Preventive Health Care. All the PIPs scored in the "High Confidence in Reported Results" range as noted in the following tables. A summary of each PIP's status and interventions is also included.

Table 2: Hospital Readmissions PIP

Hospital Readmissions	
The Hospital Readmissions PIP aims to reduce the annual rate of readmissions within 30 days for 18- to 64-year-old patients. The readmissions PIP has three measurement periods. The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge declined from 15.5% in 2022 to 15.3% in 2023. The benchmark is set at 15%. This PIP is retiring.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results

Hospital Readmissions
Interventions
• Transition of Care team assesses members upon discharge and reviews the discharge summary, assists members with scheduling appointments within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • The multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meets quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. • Utilization Management Manager pulls a daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members' needs are met.

Table 3: Timeliness of Prenatal Care PIP

Timeliness of Prenatal Care	
The timeliness of prenatal care clinical PIP was initiated in 2023 using a baseline rate from the measure year 2022 HEDIS rate. As of this review, only the baseline rate was available. The hybrid rate was 84.43% with a benchmark of 88.32%.	
Previous Validation Score	Current Validation Score
N/A	93/93=100% High Confidence in Reported Results
Interventions	
• Tablets are distributed to women in rural areas to allow them to participate in telehealth services. • The pay-for-performance incentives were expanded to encourage adherence to prenatal HEDIS recommendations. • Disparity analysis is used to identify areas where disparities exist to improve health equity and assist those members with accessing prenatal care.	

Table 4: Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The AAP PIP showed a decline in the annual rate from 2021 (78.18%) to 2022 (72.46%). The 2023 measure year rate in the quarterly quality assessment document showed a rate of 76.73%.	
Previous Validation Score	Current Validation Score

Adult Access to Preventive Health Care (AAP)	
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well-versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • Eliza application for scheduling appointments and member outreach. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.	

Utilization Management

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

Constellation evaluated ATC's Utilization Management (UM) program by reviewing policies, the UM Program Description, Provider Manual, Member Handbook, and a sample of approval, denial, appeal, and case management files. The program's purpose, scope, and goals are outlined in the UM Program Description and evaluated annually.

ATC's UM program promotes appropriate resource use through components such as 24-hour nurse triage, prior authorization, second opinions, concurrent review, complex discharge planning, ambulatory review, and retrospective reviews for medical, behavioral health, disease management, maternity, preventive care, and transitional care.

The Utilization Management Committee (UMC) oversees UM activities, approving medical necessity criteria and policies, reviewing issues, and making recommendations. The UM program is annually reviewed and approved by ATC's UMC and Quality Improvement Committee. The Medical Director oversees the program, with clinical oversight from the Behavioral Health and Pharmacy Directors.

Constellation's review of ATC's Preferred Provider Program and Policy SC.UM.54 concerning Preferred Provider Designation found that the policy had not been revised, and no process for tracking or notifying providers was implemented as stated in ATC's response and Quality Improvement Plan from the 2023 EQR. During onsite discussions, ATC could not provide additional details or clarity about the program. Additional information was requested and ATC responded that were no supplemental documents available to explain the program.

ATC has policies to guide UM decisions, including clinical criteria, timeliness, and communication standards. Licensed health professionals make all UM decisions. ATC conducts annual reliability reviews, ensuring consistency across reviewers and providing additional training or corrective actions for those below the 90% benchmark.

Standard authorizations are processed within 14 calendar days, and urgent requests are processed within three days. Two levels of medical necessity review exist, with Level I reviews not resulting in denials or reductions. Level II reviews may lead to adverse determinations, which are made by the Medical Director or a designee. Denial decisions were made consistent with the health plan's policy and contract requirements. Members are notified of the denial decision and informed about their right to appeal and request a State Fair Hearing. Peer-to-peer reviews are conducted when requested.

ATC describes the process for filing and handling a request for an appeal in policy, and in the member and provider materials. Appeals are analyzed for trends and reported to the Utilization Management Committee as reflected in quarterly committee materials. Constellation reviewed a sample of appeal files and found all were resolved timely. One appeal file was not acknowledged timely and another file was closed due to lack of timely member eligibility verification without providing resolution.

ATC's Care Management Program offers care coordination, transitional care, disease management, and specialized services for its members. Members are referred to case management from several referral sources. After a referral, outreach is made for an initial assessment, and members are stratified to an appropriate risk level to address service needs. There were two policies that reflected inconsistencies in the levels of member risk assignment. Care management activities are provided through an integrated model with a dedicated Care Manager supported by a multidisciplinary team. Performance is evaluated through audits, readmission rate monitoring, and evaluation of member satisfaction with the Care Management Program. A review of the 2023 Case Management Program Evaluation found discrepancies between the survey questions and those in the health plan's policy. Constellation's review of the sample of care management files indicated that overall, the care management activities were conducted as required. However, there were three files that did not follow the unable to contact guidelines as outlined in ATC's established policy.

Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates.

Policy CC.QI.14, Oversight of Delegated Activities, outlines the policy and procedure for the oversight of delegated activities within ATC. ATC evaluates the delegate's capacity before entering into a delegation agreement. ATC conducts an annual evaluation of the delegate's programs and performance, with a summary presented to the appropriate committee.

For this review ATC provided a list of delegates with the desk materials. ATC reported delegation agreements with 23 subcontractors. The delegated services include pharmacy services, utilization management, care management, vision services, and credentialing. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

Mental Health Parity

ATC provided descriptions for Quality and the Utilization Management programs, information on appeals and denials, network access, out of network utilization, and an analysis of the non-quantitative treatment limitation (NQTL) comparisons. Missing was a description of the behavioral health program although the goals of the behavioral health program were referenced in the Quality Improvement Program Description, page 37. Clarifying there is only one UM Program Description covering mental health/substance use disorder and medical/surgical will help with clarity going forward.

Two templates were provided to assess the Quantitative Treatment Limitations (QTLs). The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There were no financial requirements or day/session limits noted for pharmacy, emergency, inpatient, nor outpatient for medical/surgical nor for mental health categories. Thus, parity is met.

Quality Improvement Plans and Recommendations from Previous EQR

For any health plan not meeting requirements, Constellation requires the plan to submit a Quality Improvement Plan (QIP) for each standard identified as not fully met. Technical assistance is provided until all deficiencies are corrected. During the current EQR, Constellation assessed the degree to which ATC implemented the actions to address deficiencies identified during the previous EQR and found ATC failed to implement the changes needed for their Preferred Provider Program. Details regarding the 2023 QIP can be found in *Attachment 4: Assessment of Quality Improvement Plans from Previous EQR*.

Conclusions

Overall, ATC met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the QAPI program requirements described in *42 CFR § 438.330*. *Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of ATC's compliance scores specific to each of the 14 *Subpart D* and QAPI standards previously identified.

Table 5: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. C 2	1	1	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	2	2	100%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	12	9	75%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	8	89%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	38	97%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	20	100%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	3	3	100%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D	9	9	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	16	16	100%

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

As noted in the table, there were three areas that did not meet all of the standards. Those included:

- Related to Provider Selection, all of the Credentialing Committee minutes reviewed incorrectly stated the requirement for a quorum. Because of this, one meeting was held without the presence of the required quorum and credentialing decisions were made.
- For Availability of Services and Assurances of Adequate Capacity and Services, the appointment access standards for specialty emergent visits documented in the Provider Manual, the Member Handbook, and the Absolute Total Care & Wellcare New Provider Orientation document were inconsistent with the requirement documented in the *SCDHHS Contract, Section 6.2.3.1.5*. The PDF 2024 Provider & Pharmacy Directory did not include practice names/group affiliations and age groups as required by the *SCDHHS Contract, Section 3.12.3.1.1*. For the Telephone Provider Access Study conducted by Constellation, the successful contact rate declined from the previous year's rate.
- For Coordination and Continuity of Care, some of the Case Management files did not follow the unable to contact guidelines outlined in ATC's policy.

Table 6: Scoring Overview provides an overview of the scoring of the current annual review as compared to the findings of the 2023 review. For 2024, 209 out of 218 standards received a score of "Met." There were seven standards scored as "Partially Met," and two standards received a "Not Met" score.

Table 6 Scoring Overview

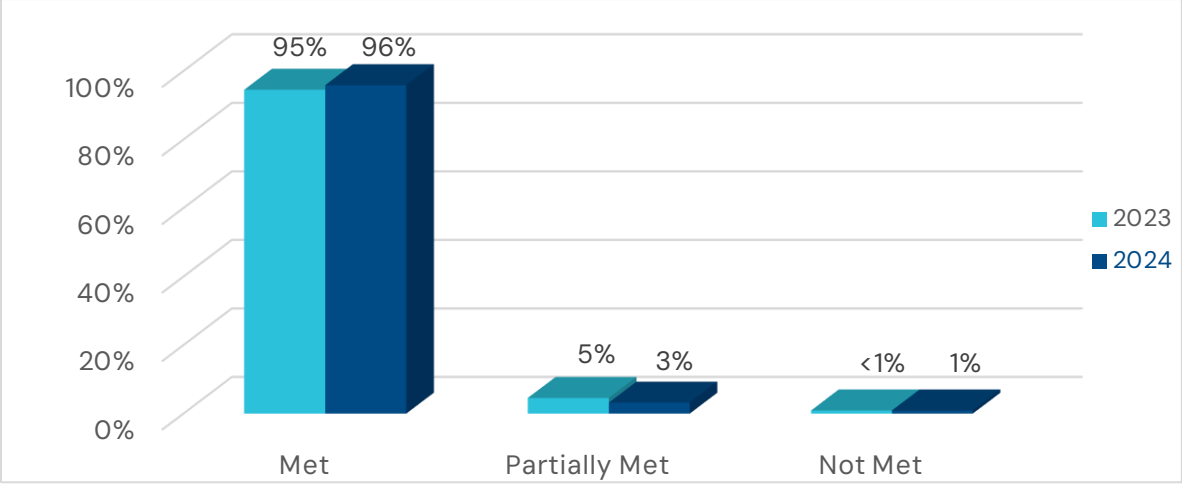
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	39	1	0	0	0	40	98%
2024	38	2	0	0	0	40	95%
Provider Services							
2023	76	4	0	0	0	80	95%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2024	73	4	1	0	0	78	94%
Member Services							
2023	32	1	0	0	0	33	97%
2024	33	0	0	0	0	33	100%
Quality Improvement							
2023	16	0	0	0	0	16	100%
2024	16	0	0	0	0	16	100%
Utilization							
2023	43	3	0	0	0	46	93%
2024	44	1	1	0	0	46	96%
Delegation							
2023	1	1	0	0	0	2	50%
2024	3	0	0	0	0	3	100%
Mental Health Parity							
2023	0	0	2	0	0	2	0%
2024	2	0	0	0	0	2	100%
Totals							
2023	207	10	2	0	0	219	95%
2024	209	7	2	0	0	218	95.87%

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

The 2024 Annual EQR shows that ATC achieved "Met" scores for 96% of the standards reviewed. The following figure provides a comparison of the current review results to the 2023 review results. Areas of the review not meeting all the standards included Administration, Provider Services, Utilization Management, and Case Management.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 7: Strengths Related to the Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Staff are trained about new/revised policies by departmental leadership and via monthly corporate emails.	✓		
ATC's staffing is sufficient to conduct all required activities and provide the required services. All required key positions are filled.	✓		
ATC has a robust disaster recovery infrastructure and conducts frequent disaster recovery testing.	✓		
Recent updates have been made to ATC's network security architecture standard to adhere to NIST 800-53r5 security standards.	✓		
The Compliance and Ethics Program Description 2024-2025 describes processes to ensure compliance with laws and regulations, and the Fraud, Waste and Abuse Plan describes processes to prevent, detect, and respond to FWA. Associated policies and procedures provide additional, detailed information to guide staff.	✓		
The 2024 Code of Conduct thoroughly addresses expectations for appropriate and ethical business conduct. Employees must attest to their understanding upon hire and annually.	✓		
Compliance training is mandatory for all employees, subcontractors, the Board of Directors, and other stakeholders.	✓		

Strengths	Quality	Timeliness	Access to Care
ATC maintains open communication channels for discussing and reporting compliance and FWA concerns. Some reporting forums allow anonymous reporting, and ATC prohibits retaliation for those making reports.	✓		
The Pharmacy Lock-in Program aims to ensure appropriate utilization of prescription medications and medical services and meets all contractual requirements.	✓		✓
Multiple policies, the Code of Conduct, the Compliance Plan, and other materials address confidentiality of member information and other protected information.	✓		
Provider Services			
ATC documents credentialing processes and requirements in the Credentialing and Recredentialing Program Description and in related policies for practitioners and organizational providers.	✓		
No issues were identified in the initial credentialing files for practitioners, initial credentialing files for organizational providers, and recredentialing files for organizational providers.	✓		
Appropriate processes are in place for suspending or terminating a practitioner's network participation for serious quality of care or service issues and for monitoring for provider sanctions and exclusions.	✓		
ATC policy correctly documents geographic access standards for PCPs, specialists, and hospitals. Goals were met for provider access as noted in the "Network Analysis - Members With and Without Access" document dated 9/30/24.			✓
ATC uses various data sources, including network adequacy reports, weekly Geo Access mapping, member satisfaction surveys, complaints, grievances, and state or federal enrollment data to evaluate the adequacy of its network.			✓
ATC's website includes downloadable cultural competency information and a hyperlink to access A Physician's Practical Guide to Culturally Competent Care, a website that offers a free, online educational program.	✓		✓
Provider compliance with appointment access standards is assessed by evaluating member satisfaction survey results, complaints, grievances, appeals, and site-specific telephonic or in-person surveys/audits. For the 2023 evaluation, goals were met for PCP routine and urgent care, pediatrics routine and urgent care, oncology routine and urgent care, and OB/GYN routine care.	✓		✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
Clinical practice and preventive health guidelines are adopted and disseminated to providers to guide members and providers when making healthcare decisions.	✓		
ATC educates providers about medical record documentation standards and assesses provider compliance with the documentation standards.	✓		
Member Services			
The sample of grievance files reviewed were all resolved within the 90-day timeframe.		✓	
Quality Improvement			
The QI Program addresses a wide range of areas including preventive health, emergency care, chronic care, behavioral health, and social determinants of health. It integrates quality improvement activities across all departments and care settings, ensuring a holistic approach to member health and service quality.	✓		
ATC utilizes advanced data analytics and health information systems to monitor, analyze, and report on performance, enabling targeted and measurable interventions.	✓		

Strengths	Quality	Timeliness	Access to Care
All three PIPs scored in the High Confidence range.	✓		
Utilization Management			
The results of the appeal file review found all were processed and the members notified timely.		✓	
ATC launched a Foster Care Program in 2023 to address service needs gaps for members receiving foster care.			✓
HALO (Health Assistance, Linkage and Outreach) is a holistic program tailored for members with substance use disorders, designed to increase member engagement, and create specialized services and personalized interventions for members.	✓		✓
Delegation			
The Delegation Oversight Program includes pre-delegation assessments, ongoing monitoring, and comprehensive annual audits. This ensures that third-party entities consistently meet performance and compliance standards, providing a robust framework for accountability.	✓		
ATC requires that all third-party entities enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights.	✓		
Mental Health Parity			
There is 100% Geo Access for psychiatrists, psychologists, and licensed therapists.			✓
Stringency with which UM criteria is applied is comparable.			✓
Procedure changes were implemented that will improve access to care, particularly for behavioral health.			✓
Policies and standards are equivalent.	✓		
BH licensed staff are well represented in utilization management.	✓		✓

Table 8: Weaknesses Related to the Quality, Timeliness, and Access to Care

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Administration				
Policy CC.COMP.22, Policy Management, outlines the processes for policy development, review, approval, and maintenance. Each policy has a Policy Manager who is responsible for annual policy review and Policy Approvers who review and approve the policy. Onsite discussion confirmed that quality and utilization management policies are also	*Quality Improvement Plan: Revise Policy CC.COMP.22, Policy Management, to include information about committee involvement in policy review and approval for the quality and utilization management policies.*	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
reviewed and approved by the Quality Improvement Committee and Utilization Management Committee, respectively. However, Policy CC.COMP.22 does not reflect this information.				
The Key Personnel list indicates there are a total of 114 FTEs for case management staff, and of the 114, 62 are in-state. However, during onsite discussion, ATC staff disputed this and stated there are no out-of-state case management staff.	*Quality Improvement Plan: Ensure all Case Management staff are located in South Carolina, as required by the SCDHHS Contract, Section 2.2.2, Exhibit 2.*	✓		
Provider Services				
Onsite discussion confirmed the quorum requirement for the Credentialing Committee is the presence of two thirds of the voting members, as documented in the Credentialing Committee Charter and Policy CC.CRED.03, Credentialing Committee. However, <u>all the Credentialing Committee Minutes</u> state the quorum is four sevenths of the voting members. Credentialing Committee minutes for meetings held from October 2023 through September 2024 reflected the presence of a quorum for all meetings except the September 2024 meeting, when evaluating against the requirement for the presence of two thirds of the voting members. Decisions were made during this meeting that required the presence of a quorum.	*Quality Improvement Plan: Revise the Credentialing Committee meeting minutes template to reflect the correct quorum requirement for the committee and ensure the presence of at least two thirds of the voting members to establish the quorum required for decision-making activities for all Credentialing Committee meetings.*	✓		
The access standard for specialty emergent visits in the Provider Manual, the Member Handbook, and the Absolute Total Care & Wellcare New Provider Orientation document state the timeframe for these visits is "immediately upon presentation at service delivery site;" however, the *SCDHHS Contract, Section 6.2.3.1.5*, states the correct timeframe is "immediately upon referral."	*Quality Improvement Plan: Revise the Provider Manual, page 8, the Member Handbook, page 14, and the Absolute Total Care & Wellcare New Provider Orientation document to reflect the correct timeframe for specialty emergency visits.*			✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
The PDF 2024 Provider & Pharmacy Directory did not include Practice names/group affiliations and age groups. Refer to the *SCDHHS Contract, Section 3.12.3.1.1.*	*Quality Improvement Plan: Revise the PDF 2024 Provider & Pharmacy Directory to include practice names/group affiliations and age groups for individual providers, as applicable.*			✓
The Provider Manual does not provide information about benefits/coverage for communicable disease services and post-stabilization services.	*Quality Improvement Plan: Revise the Provider Manual to include information about benefits/coverage for communicable disease services and post-stabilization services. Refer to SCDHHS Contract, Section 4 (Core Benefits and Services, Managed Care Coverage table).*			✓
The hyperlink to the Sickle Cell Disease guideline on ATC's website returns an error message that "The page you're looking for was not found." It does not redirect the user to the correct website.	*Recommendation: Update the website to provide the correct hyperlink to the Sickle Cell Disease guideline.*	✓		
For the Provider Access Call Study conducted by Constellation, the successful call rate declined to 61% from 67% the previous year.	*Quality Improvement Plan: Provide documentation on outreach to providers and the procedures that are in place to update provider contact information, and panel status for providers.*			✓
Member Services				
The Member Handbook does not contain information specific to the Developmental Evaluation Centers and services effective 2/1/24.	*Recommendation: Revise the Member Handbook to include information that clearly indicates services provided through the Developmental Evaluation Centers.*			✓
No information is included in the Member Handbook for members to access ATC's lifestyle management and chronic conditions programs.	*Recommendation: Revise the Member Handbook to include information on ways for members to access lifestyle management and the chronic conditions programs.*			✓
Results of the member satisfaction surveys were provided after the onsite in a PDF document that is available on ATC's website. However, the title of the document does not clearly indicate that it contains the CAHPS results.	*Recommendation: Consider featuring the CAHPS results prominently in a newsletter, email, or fax blast, or placing the results in a more visible and user-friendly location on the website for providers.*	✓		
One grievance was not acknowledged timely and was closed with 67 days remaining due to missing information and member contact.	*Recommendation: Review and revise processes and retrain staff to ensure consistent steps are taken to locate accurate contact information for members when additional information is needed to process a grievance.*			✓
Quality Improvement				

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
The Adult Preventive Care PIP showed a decline from the previous year's rate.	*Recommendation: Continue efforts to educate members on the importance of attending preventive care appointments using outreach and at events.*	✓		
Utilization Management				
ATC's Preferred Provider Program lacked details regarding the process for the identification, tracking, and notification to providers regarding the program. This was a deficiency noted during the 2023 EQR and not corrected.	*Quality Improvement Plan: Develop a program description that clearly describes ATC's Preferred Provider Program. Include the process for identifying/selecting providers, provider notification, tracking or monitoring for the program, and staff and provider education conducted regarding the program. Also, include letter templates, flyers, logs, and monitoring reports related to the program.*	✓		
One appeal was inappropriately canceled due to member eligibility.	*Recommendation: Review and revise processes and training to address the timing of member eligibility verification specific to an appeal review.*			✓
Policy CC.CM.02, Care Coordination CM Services, describes three levels of care for member stratification, which is not consistent with the four levels described in the Care Management Program Description.	*Recommendation: Ensure that policies are updated to reflect the correct risk stratification levels for members.*	✓		
In review of the 2023 Case Management Program Evaluation, it was noted that the questions provided to members were not consistent with those outlined in Policy CC.CM.08, Attachment-CM Satisfaction Survey.	*Recommendation: Update Policy CC.CM.08 Attachment-CM Satisfaction Survey to accurately reflect the care management satisfaction questions provided to members.*	✓		
Three case management files did not follow the unable to contact guidelines as outlined in Policy SC.PHCO.CM.01, Care Coordination and Case Management Program Description.	*Quality Improvement Plan: Reeducate staff on the unable to reach process and ensure adherence to the established policy standards.*	✓		
Mental Health Parity				
A higher rate of out of network authorization requests for MH/SUD was noted compared to medical/surgical.	*Recommendation: Separate data for MH from SUD to help determine root cause.*			✓
Lower level of satisfaction getting MH/SUD appointments both routine and urgent care than M/S population.	*Recommendation: Separating MH and SUD data could also help pinpoint specifically which subset of this population is having the issue of accessing care.*			✓

METHODOLOGY

The process Constellation Quality Health (Constellation) used for the External Quality Review (EQR) activities was based on protocols the Centers for Medicare & Medicaid Services (CMS) developed for the EQR of a Medicaid Managed Care Organization (MCO)/Prepaid Inpatient Health Plan (PIHP). The process focuses on the four federally mandated EQR activities of compliance determination, validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On October 7, 2024, Constellation sent notification to Absolute Total Care (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 to a teleconference to allow ATC to ask questions regarding the EQR process and the requested desk materials.

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

The second segment was a virtual onsite review conducted on December 11, 2024, and December 12, 2024. 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 in the following sections and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the Quality Assessment and Performance Improvement program requirements described in *42 CFR § 438.330,* and the Contract requirements between the health plan and SCDHHS. Strengths, Weaknesses, and Recommendations are identified where applicable. Areas of review were identified as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet in each section.

A. Administration

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

The Administration review encompasses policy development and management, staffing, information management systems, compliance and program integrity, and processes for ensuring confidentiality.

ATC develops and implements policies to guide staff in core business processes, to facilitate operations, and to ensure compliance with laws and regulations. Policies are reviewed at least annually and when there are changes in laws, regulations, and/or contractual requirements. Policy CC.COMP.22, Policy Management, outlines the processes for policy development, review, approval, and maintenance. Onsite discussion confirmed that quality and utilization management policies are reviewed and approved by the Quality Improvement Committee and Utilization Management Committee, respectively. However, Policy CC.COMP.22 does not reflect this information. Policies are maintained in RSA Archer, a policy management platform, and housed on an intranet site for staff access. Staff are trained on new/revised policies by departmental leadership. Monthly corporate emails advise staff of new/revised policies.

ATC's staffing is sufficient to conduct all required activities and provide the required services. The Organizational Chart depicts reporting relationships and is color-coded to indicate key positions, temporary/contingent personnel, and vacant positions. All required key positions are filled, and ATC reported that most of the vacant positions have been filled with ongoing recruitment efforts and/or pending employment offers for the remaining vacancies. ATC submitted a Key Personnel list which indicates that out of 114 Full Time Equivalents (FTEs) for case management staff, 62 are in-state. The *SCDHHS Contract, Section 2.2.2, Exhibit 2*, requires all case management staff to be in-state. During discussion of this, ATC staff disputed the information on the Key Personnel list and stated there are no out-of-state case management staff.

The Compliance and Ethics Program Description 2024-2025 (Compliance Plan) describes the processes to ensure compliance with laws and regulations. The Fraud, Waste and Abuse Plan (FWA Plan) addresses processes to detect, prevent, and respond to FWA, including data mining and analysis, training and education, investigations, reporting, etc. Associated policies and procedures provide additional, detailed information about compliance and FWA detection and prevention activities. The 2024 Code of Conduct covers a variety of topics including but not limited to expectations for business conduct, definitions of applicable terminology, confidentiality, information security, conflicts of interest, risk management, FWA, and reporting procedures.

ATC outlines the roles and responsibilities of the Compliance Officer and Program Integrity Coordinator in the Compliance Plan. The Compliance Officer reports to ATC's President and Board of Directors and is responsible for administering, monitoring, reviewing, and revising the

Compliance Program; coordinating with the Special Investigations Unit (SIU) and Payment Integrity Department to investigate suspected FWA; maintaining communication and reporting channels; and overseeing compliance education and training. The Program Integrity Coordinator works with the Compliance Officer to manage and investigate suspected FWA cases and coordinates FWA efforts with SCDHHS' Division of Program Integrity.

The Compliance Plan and the South Carolina Market Compliance Committee Charter provide information about ATC's Compliance Committee, including the committee's purpose, functions, membership, committee chair, meeting frequency, etc. Voting members include the Plan President, Vice President of Compliance, Chief Financial Officer/Chief Operating Officer, and additional Vice Presidents and Directors. The committee meets at least quarterly, and the quorum is established with the presence of 50% of the voting members. Compliance Committee meeting minutes for February 2024 through November 2024 confirmed the committee met at the defined frequency and the required quorum was present for each meeting. The minutes reflected detailed discussion of the agenda topics.

Compliance training is mandatory for all employees, subcontractors, the Board of Directors, and other stakeholders. For employees, the training is conducted upon employment and then annually. The training covers the Compliance Program, FWA identification, reporting mechanisms, the Code of Conduct, privacy, and confidentiality, etc. ATC's staff confirmed training regarding the Health Insurance Portability and Accountability Act (HIPAA) is provided on the first day of employment, prior to granting access to protected health information.

Employees are required to report violations of laws and company policies, illegal acts, inappropriate disclosures, and incidents of FWA. ATC encourages staff to report any concerns to supervisors/managers, senior leadership, and the health plan or corporate Compliance Officers. The Ethics and Compliance Helpline and the Fraud, Waste, and Abuse Helpline are additional reporting options that are available 24 hours per day and allow anonymous reporting. ATC protects employees from retaliation for reporting compliance and FWA concerns.

ATC's Pharmacy Lock-in Program aims to ensure appropriate utilization of prescription medications and medical services. Through this program, members are restricted to a single pharmacy and/or a limited number of prescribers based on inappropriate use of pharmacy benefits. Processes and requirements for the program are documented in policy and are compliant with contractual requirements.

Multiple policies, the Code of Conduct, the Compliance Plan, and other materials address confidentiality of member information and other protected information.

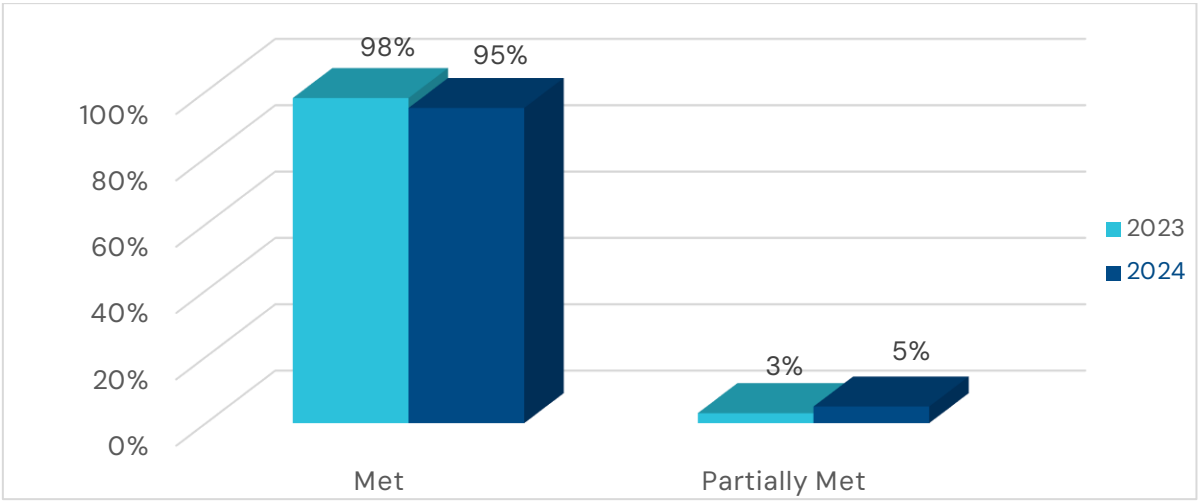
Information Management Systems Assessment

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

ATC's Information Systems Capability Assessment (ISCA) documentation indicates that ATC is capable of fulfilling the requirements of the *SCDHHS Contract*. Specifically, the organization's policies adhere to industry and regulatory best practices and are reviewed and updated regularly. Additionally, all staff are required to undergo security awareness training, and role-based security training is required on an annual basis. ATC has a robust disaster recovery infrastructure and conducts frequent disaster recovery testing, demonstrating the priority on availability. ATC processes 99% of clean claims within 30 days and 100% of all claims within 90 days.

As illustrated in *Figure 2: Administration Findings*, 95% of the Administration standards were scored as "Met." Strengths, weaknesses, and quality improvement plans are noted in the tables that follow.

Figure 2: Administration Findings



Percentages may not total 100% due to rounding

Table 9: Administration Comparative Data

Section	Standard	2023 Review	2024 Review
General Approach to Policies and Procedures	The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Partially Met

Section	Standard	2023 Review	2024 Review
Organizational Chart / Staffing	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: Case Management Staff	Met	Partially Met
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 2023 to 2024.

Table 10: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Staff are trained about new/revised policies by departmental leadership and via monthly corporate emails.	✓		
ATC's staffing is sufficient to conduct all required activities and to provide the required services. All required key positions are filled.	✓		
ATC has a robust disaster recovery infrastructure and conducts frequent disaster recovery testing.	✓		
Recent updates have been made to ATC's network security architecture standard to adhere to NIST 800-53r5 security standards.	✓		
The Compliance and Ethics Program Description 2024-2025 describes processes to ensure compliance with laws and regulations, and the Fraud, Waste and Abuse Plan describes processes to prevent, detect, and respond to FWA. Associated policies and procedures provide additional, detailed information to guide staff.	✓		
The 2024 Code of Conduct thoroughly addresses expectations for appropriate and ethical business conduct. Employees must attest to their understanding upon hire and annually.	✓		
Compliance training is mandatory for all employees, subcontractors, the Board of Directors, and other stakeholders. For employees, training is provided at employment and annually. The training covers the Compliance Program, FWA identification, reporting mechanisms, the Code of Conduct, privacy, and confidentiality, etc.	✓		
ATC maintains open communication channels for discussing and reporting compliance and FWA concerns. Some reporting forums allow anonymous reporting, and ATC prohibits retaliation for those making reports.	✓		
The Pharmacy Lock-in Program aims to ensure appropriate utilization of prescription medications and medical services and meets all contractual requirements.	✓		✓
Multiple policies, the Code of Conduct, the Compliance Plan, and other materials address confidentiality of member information and other protected information.	✓		

Table 11: Administration Weaknesses

Weakness	Quality Improvement Plan	Quality	Timeliness	Access to Care
Policy CC.COMP.22, Policy Management, outlines the processes for policy development, review, approval, and maintenance. Each policy has a Policy Manager who is responsible for annual policy review and Policy Approvers who review and approve the policy. Onsite discussion confirmed that quality and utilization management policies are also reviewed and approved by the Quality Improvement Committee and Utilization Management Committee, respectively. However, Policy CC.COMP.22 does not reflect this information.	*Quality Improvement Plan: Revise Policy CC.COMP.22, Policy Management, to include information about committee involvement in policy review and approval for the quality and utilization management policies.*	✓		
The Key Personnel list indicates there are a total of 114 FTEs for case management staff, and of the 114, 62 are in-state. However, during onsite discussion, ATC staff disputed this and stated there are no out-of-state case management staff.	*Quality Improvement Plan: Ensure all Case Management staff are located in South Carolina, as required by the SCDHHS Contract, Section 2.2.2, Exhibit 2.*	✓		

I. ADMINISTRATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.		X				Policy CC.COMP.22, Policy Management, outlines the processes for policy development, review, approval, and maintenance. ATC develops and implements policies that address core business processes to facilitate operations and ensure compliance with laws and regulations and reviews the policies at least annually. Each policy has a Policy Manager, who is responsible for annual policy review, and Policy Approvers (staff at Director or Vice President level), who review and approve the policy. Onsite discussion confirmed that quality and utilization management policies are also reviewed and approved by the Quality Improvement Committee and Utilization Management Committee, respectively. However, Policy CC.COMP.22 does not reflect this information. During the previous EQR, it was recommended that ATC revise the policy to include information regarding committee involvement in policy review and approval; however, no action was taken to address this recommendation. Policies are maintained in RSA Archer, a policy management platform, and housed on an intranet site for staff access. Staff are trained about

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						new/revised policies by departmental leadership and via monthly corporate emails that advise of new/revised policies. *Quality Improvement Plan: Revise Policy CC.COMP.22, Policy Management, to include information about committee involvement in policy review and approval for the quality and utilization management policies.*
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						The review of ATC's Organizational Chart and Key Personnel list, along with onsite discussion, showed that staffing is sufficient to conduct all required activities and to provide the required services. All required key positions are filled.
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					
1.2 Chief Financial Officer (CFO);	X					
1.3 *Contract Manager;	X					
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.1 Pharmacy Director,	X					
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,		X				The Key Personnel list indicates there are a total of 114 FTEs for case management staff, and of the 114, 62 are in-state. However, during onsite discussion, ATC staff disputed this and stated there are no out-of-state case management staff. The Organizational Chart indicated vacancies for one Care Manager and one Care Coordinator. Onsite discussion confirmed these positions have been filled. *Quality Improvement Plan: Ensure all Case Management staff are located in South Carolina, as required by the SCDHHS Contract, Section 2.2.2, Exhibit 2.*
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					
1.6.1 Quality Assessment and Performance Improvement Staff,	X					Several positions were noted as vacant on the Organizational Chart. Onsite discussion confirmed only one position remains vacant, and that an offer of employment is pending for this position.
1.7 *Provider Services Manager;	X					
1.7.1 Provider Services Staff,	X					The Organizational Chart reflects one vacancy for a Provider Engagement Administrator. Onsite discussion revealed the health plan continues recruiting efforts to fill this position.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 *Member Services Manager;	X					
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					
1.10 *Compliance Officer;	X					
1.10.1 *Program Integrity Coordinator;	X					
1.10.2 Compliance/ Program Integrity Staff;	X					
1.10.3*Program Integrity FWA Investigative/Review Staff;	X					
1.11 *Interagency Liaison;	X					
1.12 Legal Staff;	X					
1.13 *Behavioral Health Director.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					ATC's Organizational Chart depicts reporting relationships and is color-coded to indicate key positions, temporary/contingent personnel, and vacant positions.
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					ATC processes 99% of clean claims within 30 days and 100% of all claims within 90 days. In addition, ATC's documentation states, "Encounters are reviewed weekly for medical and vendor claims data. The response files (HIPAA 835 and NCPDP) are reviewed for completeness and acceptance by the state. The acceptance performance is tracked and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reported weekly while rejections are reviewed for resubmission."
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					ATC processes claims and encounter data in standardized formats including, but not limited to, 837P/837I, CMS1500, and UB04. Additionally, depending on the source, the MCO uses the following standardized forms: • Hospital - UB92/UB04 • Physician - CMS 1500 • Drug – NCPDP • Nursing home - CMS 1500 • Home health - CMS 1500 • Mental health - UB92/UB04 & CMS 1500 • Dental - UB92/UB04 & CMS 1500
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					The ISCA documentation provided by ATC notes that systems can record the initial enrollment date of an enrollee and associate prior encounter data across various product lines. Furthermore, these systems are capable of monitoring enrollees who transition between different product lines. Additionally, unique member ID numbers are based on the Medicaid ID on the 834 files. Finally, reports are in place to assist in identifying any duplicate members. If a duplicate member is found, the member is merged within the system and both Medicaid IDs are retained.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					ATC uses its Electronic Data Warehouse as the source to produce Medicaid performance reports. For HEDIS performance and reporting, ATC uses the "Catalyst Quality Spectrum Insight" (aka QSIXL) application. QSIXL is an NCQA-approved system. Report production is logged, and the logs include statistics such as

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						start time, run durations, complete times, abends, warnings, and input/output statistics.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					ATC has implemented strict policies and procedures to protect and restrict unauthorized access to protected health information. Some of the measures highlighted in the ISCA documentation include diskless desktop PC's, encrypted laptop hard drives, and monitoring/tracking of mobile devices. ATC's information technology systems are housed within secure data centers. These centers have security guards on duty and monitored surveillance cameras, and electronic badges are required to enter the premises.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					ATC addresses data security according to HIPAA and industry best practices: • Users are only granted the access needed to support their job functions. User access changes require management approval. • Logins are audited, and accounts are disabled after multiple failures. • Policies include requirements for complex passwords, secure file systems, encryption, and strict procedures surrounding the handling and use of Protected Health Information.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					ATC's disaster recovery (DR) plan details the MCO's approach to determining a disaster or interruptive incident and how it will respond. The DR plan leverages the organization's multiple data centers by designating each as a primary or secondary site. Data is mirrored between the primary and secondary sites so that failover can occur to the secondary if

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recovery is necessary. ATC successfully tested its DR plan multiple times in 2024 with only two issues discovered. ISCA documentation notes that issues were assigned a corrective action plan and have already been resolved.
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 2024-2025 (Compliance Plan) describes ATC's Compliance and Ethics Program, which focuses on compliance with laws and regulations, fraud prevention, and ethical business practices. The Compliance Plan addresses the program's purpose and scope, program elements, compliance and FWA processes, reporting, etc. Associated policies and procedures provide additional, detailed information about compliance and FWA detection and prevention activities.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The 2024 Code of Conduct, most recently approved by the Centene Board of Directors in December 2023, covers a variety of topics including but not limited to definitions of applicable terminology, confidentiality, information security, conflicts of interest, risk management, FWA, and reporting procedures. The Code of Conduct specifies that it is applicable to all directors, officers, employees, subcontractors, vendors, stakeholders, and others. It also states, "All employees, as a condition of their employment, are required to complete and sign a questionnaire

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						acknowledging receipt and understanding of this Code."
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Plan outlines the roles and responsibilities of the Compliance Officer, who reports to ATC's President and Board of Directors. The Compliance Plan states the Program Integrity Coordinator coordinates with the Compliance Officer to manage and investigate suspected FWA cases and coordinates FWA efforts with SCDHHS' Division of Program Integrity.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						Attachments 21 through 23 of the Compliance Plan include the ATC Compliance Department Organizational Chart, the SIU Organizational Chart, and the Payment Integrity Organizational Chart.
2.4 Information about the Compliance Committee;						The Compliance Plan provides detailed information about ATC's Compliance Committee, and addresses the committee's functions, membership, the committee chair, meeting frequency, etc.
2.5 Compliance training and education;						Information about compliance training, which is mandatory for all employees, subcontractors, the Board of Directors, and other stakeholders, is included in the Compliance Plan. For employees, training is provided at employment and annually. The training covers the Compliance Program, FWA identification, reporting mechanisms, the Code of Conduct, privacy, and confidentiality, etc. The health plan maintains records of compliance training attendance and completion.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy CC.COMP.10, Risk, Ethics & Compliance Training, provides additional information about compliance training, and states compliance training is assigned within 90 days of hire and failure to complete required training "may result in disciplinary measures up to and including termination of employment…" Onsite discussion revealed that training regarding HIPAA and confidentiality are provided on the first day of employment and prior to granting access to protected health information.
2.6 Lines of communication;						ATC's Compliance Plan emphasizes the importance of open communication channels to support a culture of compliance and ethical behavior, and states the Compliance Department communicates with staff via emails, written memoranda, newsletters, etc. As noted, employees are required to report violations of laws and company policies, illegal acts, inappropriate disclosures, and incidents of FWA. Staff are encouraged to report concerns to their supervisor, manager, the Compliance Officer, any member of the ATC Senior Leadership team, or the Centene Compliance Officer. ATC maintains additional reporting avenues, including the Ethics and Compliance Helpline and the Fraud, Waste, and Abuse Helpline, both of which are available 24 hours per day and allow anonymous reporting. Contact information for reporting methods is readily available to all employees, providers, and others. Additionally, ATC protects employees from retaliation for reporting compliance and FWA concerns.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Additional information is found in Policy CC.COMP.03, Speaking Up: Reporting Concerns, Policy Violations, Misconduct and Non-compliance.
2.7 Enforcement and accessibility;						Policies outline the potential disciplinary actions for noncompliance with laws and company policies and standards. These disciplinary actions can range from oral warnings to termination, depending on the severity of the violation. Disciplinary standards are communicated to employees upon hire and during Compliance and Ethics training sessions. As noted in the Compliance Plan, disciplinary actions are applied consistently to ensure fairness.
2.8 Internal monitoring and auditing;						The Compliance Plan provides an overview of internal auditing and monitoring activities, which include: • Annual assessments to ensure compliance with contractual requirements • Ad hoc functional area audits to assess specific risks or concerns • Monitoring and auditing of health plan operations and functional departments for compliance with contractual requirements and laws by the Internal Audit Department ATC takes immediate action to address identified risks and/or violations and monitors the corrective action to evaluate its effectiveness. Detailed information about internal auditing and monitoring activities conducted by the Compliance Department is found in Policy CC.COMP.41, Compliance Auditing and

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Monitoring Program – Medicaid and Commercial/Marketplace.
2.9 Response to offenses and corrective action;						Upon discovery of an issue, the Compliance staff validates findings with management and documents management's response to recommendations for improvement. The applicable department is responsible for executing the corrective action plan and the Compliance Department monitors the effectiveness of the corrective actions.
2.10 Data mining, analysis, and reporting;						The Compliance Plan addresses the use of Analytical Data Mining by the SIU to identify patterns, potential payment errors, utilization trends, and other indicators of potential FWA. The document also references the use of Healthcare Fraud Shield (HCFS) and the FWAShield platform in its efforts for fraud detection. Additionally, ATC uses the PISCES application to identify suspect providers. The FWA Plan also addresses data mining as part of the process for identifying potential FWA. The activities and tools include the HCFS and ad hoc and member data mining activities to identify potential FWA and to detect unusual patterns in member behavior.
2.11 Exclusion status monitoring.						ATC routinely checks federal and state exclusion, termination, suspension, prepayment, and behavioral health action databases to determine whether providers have been sanctioned or have lost their professional licenses due to Medicaid fraud. Information about these processes is included in the Compliance Plan. In addition, Policy CC.COMP.36, Exclusion Screening for Health

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Care Programs, and its related addendum, address exclusion status monitoring for beneficial owners, the Board of Directors, employees, contingent workers, and vendors. The review confirmed ATC implemented the quality improvement plan to include the process for conducting queries of the SSDMF for subcontractors and persons with ownership or control interest or who are agents or managing employees of the MCO.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The South Carolina Market Compliance Committee Charter outlines the purpose, composition, meeting requirements, goals, functions, and responsibilities of ATC's Compliance Committee in the oversight and implementation of the Compliance Program. This committee reports to the Board of Directors. The Plan President and Compliance Officer co-chair the Compliance Committee and voting members include the Plan President, Vice President of Compliance, Chief Financial Officer/Chief Operating Officer, and additional Vice Presidents and Directors. The Compliance Committee meets at least quarterly, and the quorum is established with the presence of 50% of the voting members. Minutes for the Compliance Committee meetings held from February 2024 through November 2024 reflected the presence of the required quorum for each meeting and detailed discussion of the agenda topics.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The Compliance Plan addresses claims audits, use of data systems to detect billing irregularities and fraudulent or abusive billing practices, claims sampling and edits to identify irregularities and evaluate compliance, post-processing review of claims to detect issues, etc. The FWA Plan addresses processes to detect, prevent, and respond to FWA, including data mining and analysis, training and education, investigations, reporting, etc. Additional detailed information about processes to prevent and detect FWA is found in related policies.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Compliance Plan provides an overview of investigative activities for potential fraud, waste, and abuse within the organization. The FWA Plan addresses investigations in detail. The information includes processes for: • Referral, intake, and triage • Preliminary review • Pre-payment and post-payment review of medical records • Onsite visits for investigations • Witness interviews • Final report preparation with recommendation for next steps
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The FWA Plan addresses payment suspensions and recoupments. These processes are also addressed in Policy SC.CLMS.01, ATC State Suspended Provider Payment Withhold, and Policy CC.COMP.16.01, Service Verification.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy CC.PHAR.18, Pharmacy Lock-in Program, states that the aim of the Pharmacy Lock-in Program is to ensure appropriate utilization of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						prescription medications and medical services to identify potential fraud and abuse. The policy indicates that members may be restricted to a single pharmacy and/or a limited number of prescribers based on inappropriate use of pharmacy benefits or if requested by the primary care physician (PCP). Addendum C of Policy CC.PHAR.18, Pharmacy Lock-in Program, provides detailed information regarding criteria for restricting members into the Pharmacy Lock-in Program; reviewing referrals for the program from SCDHHS; member notification of restriction into the program; the timeframe for implementing the restriction; the provision of a 72-hour emergency supply of medication; etc.
I E. Confidentiality *42 CFR § 438.224*						
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	X					Multiple policies, the Code of Conduct, the Compliance Plan, and other materials address confidentiality of member information and other protected information.

B. Provider Services

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

The Provider Services review includes credentialing and recredentialing processes and file review, provider education processes, preventive health and clinical practice guidelines, continuity of care, processes for assessing provider compliance with medical record documentation standards, and processes for validation of network adequacy.

Provider Credentialing and Selection

The Credentialing and Recredentialing Program Description provides an overview of ATC's credentialing and recredentialing processes. Detailed information about credentialing and recredentialing requirements and processes is included in Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, and Policy CC.CRED.09, Organizational Assessment and Reassessment. The review of these documents confirmed ATC implemented the quality improvement plan from the previous EQR to include the timeframe for processing credentialing applications for organizational providers in Policy CC.CRED.09.

The initial credentialing files for practitioners and the initial credentialing and recredentialing files for organizational providers were compliant with all requirements and no issues were identified. However, the practitioner recredentialing files revealed issues related to verification dates. In one file, the Drug Enforcement Agency (DEA) verification appears to have been conducted more than a year before the recredentialing decision date, which is out of compliance with the requirements of Policy CC.CRED.01, Practitioner Credentialing & Recredentialing. In one file, the evidence of the query of the South Carolina Terminated for Cause list shows that the list was dated one month after the recredentialing decision date.

ATC's Credentialing Committee is chaired by the Chief Medical Director, meets monthly, and uses a peer-review process to make credentialing decisions. Committee members include practitioners with specialties in pediatrics, anesthesiology, family medicine, internal medicine, psychiatry, and emergency medicine. Onsite discussion confirmed the quorum requirement for the Credentialing Committee is the presence of two thirds of the voting members. This corresponds with the quorum requirement documented in the Credentialing Committee Charter and Policy CC.CRED.03, Credentialing Committee. The Credentialing Committee minutes submitted for review incorrectly indicated the quorum requirement as four sevenths of the voting members. Because the quorum was incorrectly calculated using a standard of four sevenths of the voting members, one meeting (September 2024) did not have the presence of a quorum. Credentialing decisions were made during this meeting.

Health plan policy documents the process followed when potential quality of care or quality of services issues are reported and/or identified. The process includes Medical Director review and referral to the Peer Review Committee (PRC). The PRC membership includes the Chief Medical Director and/or Medical Director, the VP or Director of the Quality Department, and at least three network practitioners, one of which has the same or a similar specialty as the case under review. The PRC determines the final severity level and recommends corrective actions, which may include restriction, suspension, or termination of network participation. The recommendation is presented to the Credentialing Committee and/or the Board of Directors for a final determination.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

ATC conducts orientation for all newly contracted providers, ancillary providers, and hospitals who are not part of an existing in-network group or facility to ensure they are able to function within ATC's network. The orientation is conducted in person or virtually within 30 business days of the provider becoming active with ATC. Ongoing provider education is conducted through a variety of forums, including face-to-face visits with Provider Engagement Administrators, Joint Operations Committee meetings, and regional provider training sessions. The 2024 Medicaid Provider Manual (Provider Manual) is an additional source of information for network providers; however, it does not provide information about benefits/coverage for communicable disease services and post-stabilization services.

Providers are educated about clinical practice guidelines (CPGs) and preventive health guidelines (PHGs). The guidelines are disseminated to providers based on specialty and are available to all providers upon request. Guidelines may also be disseminated through provider orientation materials, newsletters, mailings, fax blasts, etc. Providers are encouraged to use the guidelines to assist in developing personalized treatment plans for members and are informed that ATC may measure compliance with these guidelines through Healthcare Effectiveness Data and Information Set (HEDIS) measure monitoring and medical record audits. The Provider Manual refers the reader to ATC's website to access the guidelines. On ATC's website, the hyperlink to one guideline returns an error message ("The page you're looking for was not found."). It does not redirect the user to the correct website.

Providers are also educated about medical record documentation standards and monitored for compliance through medical record audits. The Medicaid Medical Record Review 2024 Annual Audit Report was presented during the Quality Improvement Committee (QIC) meeting on 8/27/24. A total of 355 records were audited across the 71 practitioners. All practitioners received passing scores, with an overall score of 93.7%. This was a 0.5 percentage-point increase from the previous year.

Network Adequacy Validation

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

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

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

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

The following is an overview of the results for each activity conducted to assess network adequacy.

Provider Network File Questionnaire

The Provider Network File Questionnaire was reviewed. ATC uses Portico as the data management system. Verification is conducted via a roster validation process. The member facing directory is updated daily. Quest Analytics time/distance reports are run weekly.

Availability of Services

A state-specific addendum to Policy CC.PRVR.47, Evaluation of Practitioner Availability, appropriately defines geographic access standards for PCPs, specialists, and hospitals and states the health plan's goal is that 90% of members have access within the defined standards. The review confirmed ATC implemented the quality improvement plan from the previous year to revise

the attachment to Policy CC.PRVR.47 to include the geographic access standards for primary care providers and specialty care providers.

ATC evaluates the geographic adequacy of its network annually. Data sources for these evaluations include network adequacy reports, Geo Access mapping, member satisfaction survey results, and complaint/grievance data regarding satisfaction with practitioner availability. Onsite discussion confirmed ATC runs Geo Access reports weekly and that access is evaluated on a county-by-county basis. The "Network Analysis - Members With and Without Access" document dated 9/30/24 indicates appropriate geographic parameters were used to measure access for all Status 1 provider types. Goals were met for the percentages of members with appropriate geographic access to all Status 1 providers. Review of the printed and online provider directories, along with information provided after the onsite, confirmed ATC contracts with all required Status 2 provider types.

The 2025 Network Development Plan provides detailed information about network development and monitoring activities and addresses immediate short-term interventions to resolve barriers and fill network gaps. Examples include implementing single-case agreements, working with providers who have closed panels to make an exception to see a member, arranging member transportation, and maintaining relationships with in-home and telehealth providers. The Network Development Plan also addresses long-term interventions, which may include attempts to contract with providers with prior single-case agreements, quickly addressing provider requests to join the network, identifying new providers in the area, etc.

The online Provider Directory ("Find a Provider") includes all required elements. However, the PDF 2024 Provider & Pharmacy Directory did not include practice names/group affiliations and age groups as required by the *SCDHHS Contract, Section 3.12.3.1.1*. Data for the web-based directory is sourced from the provider data management (PDM) system and updated automatically to ensure current information. The Provider Data Excellence team updates the PDM system within 30 calendar days of receiving new information from providers or audits.

Appointment access standards are documented in a policy, the Provider Manual, the Member Handbook, and the Absolute Total Care & Wellcare New Provider Orientation document. Most of the documented standards are compliant with the contractual requirements; however, for specialty emergent visits, the Provider Manual, Member Handbook, and the New Provider Orientation document state the timeframe for these visits is "immediately upon presentation at service delivery site," which is inconsistent with the *SCDHHS Contract, Section 6.2.3.1.5*.

ATC's process for evaluating provider compliance with appointment access includes evaluating member satisfaction survey data, member complaints, grievances, and appeals, and site-specific telephonic or in-person surveys/audits. The 2024 Accessibility of Services Report indicates an

audit was conducted by a vendor in Q2 2023. For the 2023 evaluation, goals were met for PCP routine and urgent care, pediatrics routine and urgent care, oncology routine and urgent care, and obstetrics/gynecology (OB/GYN) routine care. Goals were not met for PCP after-hours access and OB/GYN urgent care. Identified barriers and interventions to address the barriers were documented. Results were presented to the QIC on 8/27/24.

ATC conducts annual assessments of the cultural, ethnic, racial, and linguistic needs of members to determine if the provider network can meet those needs. The Provider Manual gives an overview of cultural competency and informs that providers are required to offer medical interpreters, consider members' cultural factors in treatment plans, and participate in cultural competency training. The Provider Manual refers the reader to ATC's website for further information. ATC's website includes hyperlinks to A Physician's Practical Guide to Culturally Competent Care (a free, online educational program that offers education credits for physicians, physician assistants, and nurse practitioners) and additional cultural competency resources.

The State has documented time/distance requirements for primary care, OB/GYN, and specialty providers. The current EQR found that ATC's methods for assessing network adequacy are reliable, including conducting provider access studies and network adequacy time/distance assessments with Quest Analytics software.

Provider Access and Availability Study

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

As part of the annual EQR process for ATC, a provider access study focusing on primary care providers was conducted. ATC gave Constellation a list of current providers, from which a population of 2,012 unique PCPs was found. A sample of 180 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. For the Telephone Provider Access Study conducted by Constellation, 105 out of 172 calls were successfully answered when omitting the eight calls answered by personal or general voicemail messaging services. This equates to a 61% successful contact rate. When compared to last year's results of 67%, this is a non-significant decline in the successful contact rate. See *Table 12*.

Table 12: Telephonic Access Study Answer Rate Comparison

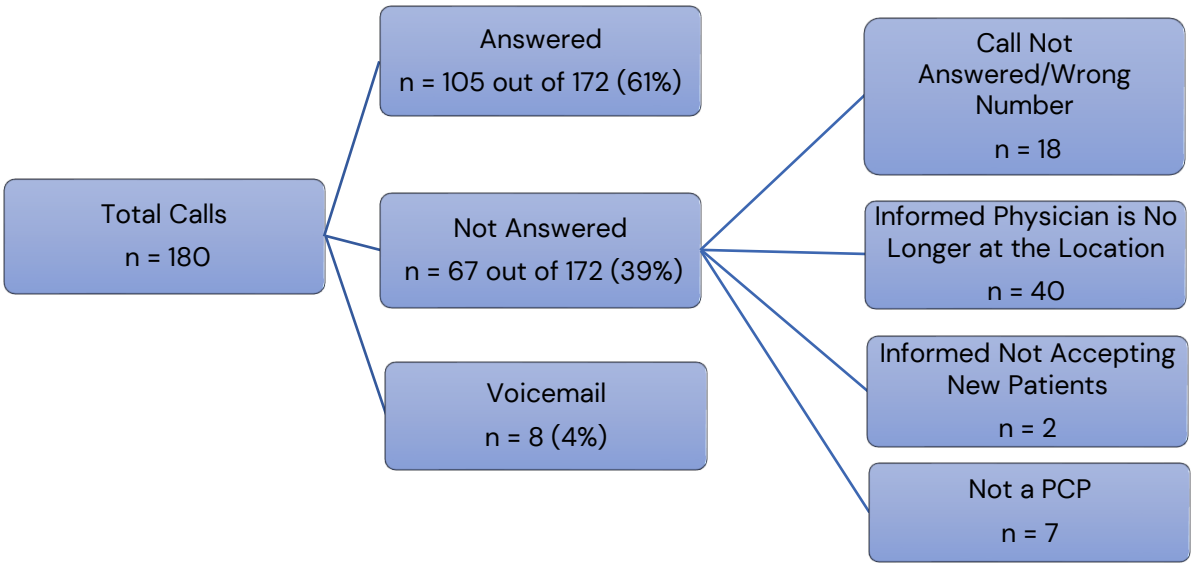
Review Year	Sample Size	Answer Rate	Fisher's Exact p-value
2023	189	67%	.230
2024	180	61%	

For the 67 calls that were not answered successfully, most were due to the provider no longer being active at that location (n = 40, 60%). The next most common reason was no answer or wrong number (n = 18, 27%), followed by the caller being informed that the provider was not a PCP (n = 7, 10%). The least common reason for an unsuccessful call was the caller getting immediate notification that the provider was not accepting new patients and the respondent ending the call (n = 2, 3%).

Of 105 providers who were successfully contacted, 71 (68%) accepted ATC and 34 (32%) did not accept ATC. Of the 71 who are accepting ATC, 51 (72%) are accepting new patients; 20 (28%) are not accepting new patients. A routine appointment was available within the contractual requirement of 30 days for 16 of the 51 providers (31%) that are accepting new patients and outside the required timeframe for 18 (35%). For 17 of the 51 calls (33%), the surveyor was unable to obtain an appointment date due to the provider requesting more information, such as medical records or insurance number of the member.

Results of the call study are displayed in *Figure 3*.

Figure 3: Provider Access Study Results



As noted in *Figure 4: Provider Services Findings*, 94% of the standards in the Provider Services section were scored as "Met." Strengths, weaknesses, recommendations, and quality improvement plans are included in the tables that follow.

Figure 4: Provider Services Findings

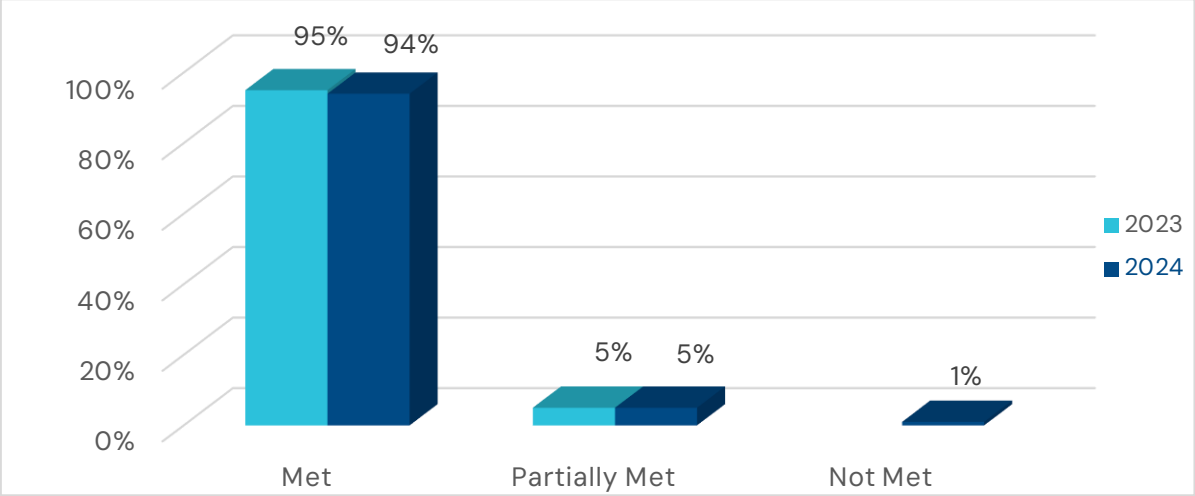


Table 13: Provider Services Comparative Data

Section	Standard	2023 Review	2024 Review
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Met
	Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Met	Partially Met
Adequacy of the Provider Network	The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following: Members have a primary care physician located within a 30-mile radius of their residence	Partially Met	Met

Section	Standard	2023 Review	2024 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	Partially Met	Met
	The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	Met	Partially Met
	The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.	Met	Not Met
Provider Education	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 14: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
ATC documents credentialing processes and requirements in the Credentialing and Recredentialing Program Description and in related policies for practitioners and organizational providers.	✓		
No issues were identified in the initial credentialing files for practitioners, initial credentialing files for organizational providers, and recredentialing files for organizational providers.	✓		
Appropriate processes are in place for suspending or terminating a practitioner's network participation for serious quality of care or service issues and for monitoring for provider sanctions and exclusions.	✓		
ATC policy correctly documents geographic access standards for PCPs, specialists, and hospitals. Goals were met for provider access as noted in the "Network Analysis – Members With and Without Access" document dated 9/30/24.			✓
ATC uses various data sources, including network adequacy reports, weekly Geo Access mapping, member satisfaction surveys, complaints, grievances, and state or federal enrollment data to evaluate the adequacy of its network.			✓

Strengths	Quality	Timeliness	Access to Care
ATC's website includes downloadable cultural competency information and a hyperlink to access A Physician's Practical Guide to Culturally Competent Care, a website that offers a free, online educational program.	✓		✓
Provider compliance with appointment access standards is assessed by evaluating member satisfaction survey results, complaints, grievances, appeals, and site-specific telephonic or in-person surveys/audits. For the 2023 evaluation, goals were met for PCP routine and urgent care, pediatrics routine and urgent care, oncology routine and urgent care, and OB/GYN routine care.	✓		✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
Clinical practice and preventive health guidelines are adopted and disseminated to providers to guide members and providers when making healthcare decisions.	✓		
ATC educates providers about medical record documentation standards and assesses provider compliance with the documentation standards.	✓		

Table 15: Provider Services Weaknesses

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Onsite discussion confirmed the quorum requirement for the Credentialing Committee is the presence of two thirds of the voting members, as documented in the Credentialing Committee Charter and Policy CC.CRED.03, Credentialing Committee. However, all the Credentialing Committee Minutes state the quorum is four sevenths of the voting members. Credentialing Committee minutes for meetings held from October 2023 through September 2024 reflected the presence of a quorum for all meetings except the September 2024 meeting, when evaluating against the requirement for the presence of two thirds of the voting members. Decisions were made during this meeting that required the presence of a quorum.	*Quality Improvement Plan: Revise the Credentialing Committee meeting minutes template to reflect the correct quorum requirement for the committee and ensure the presence of at least two thirds of the voting members to establish the quorum required for decision-making activities for all Credentialing Committee meetings.*	✓		
Appointment access standards are documented in Policy SC.PRVR.15, Evaluation of the Accessibility of Services, the Provider Manual, and the Member Handbook. All are compliant with the contractual requirements with the exception of specialty emergent visits. For	*Quality Improvement Plan: Revise the Provider Manual, page 8, the Member Handbook, page 14, and the Absolute Total Care & Wellcare New Provider Orientation document to reflect the correct timeframe for specialty emergency visits.*			✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
this category, the Provider Manual, page 8, the Member Handbook, page 14, and the Absolute Total Care & Wellcare New Provider Orientation document state the timeframe for these visits is "immediately upon presentation at service delivery site;" however, the *SCDHHS Contract, Section 6.2.3.1.5.*, states the correct timeframe is "immediately upon referral."				
The PDF 2024 Provider & Pharmacy Directory did not include Practice names/group affiliations and age groups. Refer to the *SCDHHS Contract, Section 3.12.3.1.1.*	*Quality Improvement Plan: Revise the PDF 2024 Provider & Pharmacy Directory to include practice names/group affiliations and age groups for individual providers, as applicable.*			✓
The Provider Manual does not provide information about benefits/coverage for communicable disease services and post-stabilization services.	*Quality Improvement Plan: Revise the Provider Manual to include information about benefits/coverage for communicable disease services and post-stabilization services. Refer to SCDHHS Contract, Section 4 (Core Benefits and Services, Managed Care Coverage table).*			✓
The hyperlink to the Sickle Cell Disease guideline on ATC's website returns an error message that "The page you're looking for was not found." It does not redirect the user to the correct website.	*Recommendation: Update the website to provide the correct hyperlink to the Sickle Cell Disease guideline.*	✓		
For the Provider Access Call Study conducted by Constellation, the successful call rate declined to 61% from 67% the previous year.	*Quality Improvement Plan: Provide documentation on outreach to providers and the procedures that are in place to update provider contact information, and panel status for providers.*			✓

II. PROVIDER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The following documents were reviewed: • Credentialing and Recredentialing Program Description • Policy CC.CRED.01, Practitioner Credentialing & Recredentialing • Policy CC.CRED.09, Organizational Assessment and Reassessment • Policy CC.CRED.04, Nondiscriminatory Credentialing and Recredentialing The review confirmed ATC implemented the quality improvement plan from the previous EQR to include the timeframe for processing credentialing applications for organizational providers in Policy CC.CRED.09.
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				An overview of the Credentialing Committee is found in the Credentialing and Recredentialing Program Description. Policy CC.CRED.03, Credentialing Committee, outlines the structure and protocols for the Credentialing Committee and the peer-review process used to make credentialing decisions. The 2024 Quality Program Description includes the charter for the Credentialing Committee.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The charter defines the purpose and responsibilities of the Credentialing Committee, and indicates the committee is chaired by the Chief Medical Director or a participating network practitioner. The committee meets monthly, and members are expected to attend 75% of the scheduled meetings. The charter defines the voting members of the committee membership as the Chief Medical Director and network practitioners, whose specialties may include family practice, internal medicine, OB/GYN, behavioral health, high-volume specialists, mid-level practitioners, etc. Onsite discussion confirmed the quorum requirement for the Credentialing Committee is the presence of two thirds of the voting members, as documented in the Credentialing Committee Charter and Policy CC.CRED.03, Credentialing Committee. However, all of the Credentialing Committee minutes reviewed stated the quorum is four sevenths of the voting members. Credentialing Committee minutes for meetings held from October 2023 through September 2024 confirmed the committee meets monthly. The minutes reflected the presence of a quorum (two thirds of the voting members) for all meetings except the September 2024 meeting. Decisions were made during this meeting that required the presence of a quorum. Members of the Credentialing Committee include practitioners with specialties in pediatrics,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						anesthesiology, family medicine, internal medicine, psychiatry, and emergency medicine. *Quality Improvement Plan: Revise the Credentialing Committee meeting minutes template to reflect the correct quorum requirement for the committee and ensure the presence of at least two thirds of the voting members to establish the quorum required for decision-making activities for all Credentialing Committee meetings.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.1.15 Additional Requirements for Nurse Practitioners.	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
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					In one recredentialing file, the DEA verification appears to have been conducted more than a year before the recredentialing decision date. The DEA document in the file indicates a verification date of 2/14/23 and a review date of 2/14/24, with a decision date of 2/15/24. Policy CC.CRED.01, Practitioner Credentialing & Recredentialing, page 54-56, states, "Certain minimum requirements must be met for credentialing committee/Medical Director review to occur…" "Minimum administrative requirements that must be met include:" "iii. Contains primary and/or secondary source verification information collected not more than 120 calendar days prior to placing into the "Ready for Committee" status in the credentialing system of record. And, not more than 180 calendar days at the time of credentialing decision;"

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Ensure verification activities for credentialing and recredentialing elements are conducted within the required timeframes.
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					In one file, the query of the SC Terminations for Cause list appears to have been conducted after the recredentialing decision date. Documentation in the file indicates the SC Terminations list is dated 6/6/24, with a recredentialing decision date of 5/6/24. *Recommendation: Ensure verification activities for credentialing and recredentialing elements are conducted within the required timeframes.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.14 Additional Requirements for Nurse Practitioners.	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Health plan policy documents the process followed when potential quality of care or quality of services issues are reported and/or identified. The Medical Director reviews applicable cases, determines the severity level, and makes recommendations for any needed actions, which may include referral to the Peer Review Committee (PRC). The PRC membership includes the Chief Medical Director and/or Medical Director, the VP or Director of the Quality Department, and at least three network practitioners, one of which has the same or a similar specialty as the case under review. The

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PRC reviews the case and determines the final severity level and recommends corrective actions, which may include restriction, suspension, or termination of network participation. The recommendation is presented to the Credentialing Committee and/or the Board of Directors for a final determination. The processes are described in Policy CC.QI.17, Potential Quality of Care Incidents, Policy CC.QI.19, Peer Review Committee and Process, and Policy CC.CRED.07, Practitioner Disciplinary Action and Reporting.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					ATC monitors for provider sanctions and exclusions through the routine monitoring, which includes: • Medicare/Medicaid-specific exclusions or NPDB reports • Sanction information from all state licensing boards, Medicare, and Medicaid sources • The System for Awards Management • State-specific exclusion lists, as applicable • The Office of Inspector General's List of Excluded Individuals/Entities A description of these ongoing monitoring activities is found in Policy CC.CRED.06, Ongoing Monitoring of Sanctions & Complaints.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1. The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					The addendum to Policy CC.PRVR.47, Evaluation of Practitioner Availability, appropriately defines geographic access standards for PCPs and states the health plan's goal is that 90% of members have access within the defined standards. The review confirmed that ATC implemented the quality improvement plan from the previous year to revise the attachment to Policy CC.PRVR.47 to include the geographic access standards for primary care providers. The "Network Analysis - Members With and Without Access" document dated 9/30/24 indicates appropriate geographic parameters were used for all PCP provider types and that all goals were met. The percentage of members with the required access ranged from 96.9% to 99.9%. This "Network Analysis - Members With and Without Access" document also indicated the average distance/time measurement for the first through fifth closest providers for each provider type.
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,	X					The addendum to Policy CC.PRVR.47, Evaluation of Practitioner Availability, appropriately defines geographic access standards for specialists and hospitals, and states the health plan's goal is that 90% of members have access within the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
the member may utilize an out-of-network specialist with no benefit penalty.						defined standards. The review confirmed ATC implemented the quality improvement plan from the previous year to revise the attachment to Policy CC.PRVR.47 to include the geographic access standards for specialty care providers. The "Network Analysis - Members With and Without Access" document dated 9/30/24 indicates appropriate geographic parameters were used for all Status 1 provider types. The percentage of members with the required access ranged from 99.6% to 99.9%. The document also indicates average distance/time measurement for the first through fifth closest providers for each provider type. Review of the printed and online provider directories, along with additional information submitted after the onsite, confirmed ATC contracts with all required Status 2 provider types.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					ATC's Provider Relations Department measures practitioner type and availability annually and considers additional factors including member satisfaction with practitioner availability, complaints, grievances, and state or federal enrollment data. When opportunities for improvement are identified, ATC develops interventions and measures their effectiveness annually. These interventions may include expanding the network, improving scheduling systems, targeting specific specialties or geographic areas for recruitment, and addressing provider dissatisfaction. This

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						process is documented in Policy CC.PRVR.47, Evaluation of Practitioner Availability.
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					The 2024 Quality Program Description includes cultural competency information and states ATC follows the guidance found in Policy CC.QI. CLAS.29, Cultural Competency and Linguistic Assistance Policy (C&L), the *SCDHHS Contract*, and the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care developed by the federal Office of Minority Health. The Provider Manual gives an overview of cultural competency and outlines ATC's commitment to providing culturally and linguistically appropriate services and ensuring equitable services for the member population. Providers are required to offer medical interpreters, consider members' cultural factors in treatment plans, and participate in cultural competency training. The Provider Manual refers the reader to ATC's website for further information. ATC's website includes hyperlinks to A Physician's Practical Guide to Culturally Competent Care, a free, online educational program that offers education credits, as well as the following cultural competency resources: • Culturally and Linguistically Appropriate Services Program Description • Americans with Disabilities Act Disability Awareness Training Quick Reference Guide • Cultural Competency Quick Reference Guide • Cultural Humility and Unconscious Bias in Healthcare

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The 2025 Network Development Plan provides detailed information about network development and monitoring activities and addresses immediate short-term interventions to resolve barriers and fill network gaps. Examples include implementing single-case agreements to allow members to see non-participating providers, working with providers who have closed panels to make an exception to see a member, arranging transportation for members to see providers when transportation is a barrier, and maintaining relationships with in-home and telehealth providers who can provide necessary care to members. The Network Development Plan also addresses long-term interventions to resolve barriers and gaps. These include attempting to contract with providers who have had single-case agreements implemented, quickly addressing provider inquiries to join the network, identifying new providers in the area, etc. If there are not enough providers in an area to provide adequate access, ATC reviews the existing network providers' panel statuses (open/closed) to determine if additional capacity can be addressed within the network and encouraging network providers to extend hours and expand access points.
1.6 The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					The Provider Network File Questionnaire was reviewed. ATC uses Portico as the data management system. Verification is conducted via a roster validation process. The member facing directory is updated daily. Quest Analytics time/distance reports are run weekly.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
2.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.		X				Appointment access standards are documented in Policy SC.PRVR.15, Evaluation of the Accessibility of Services, the Provider Manual, the Member Handbook, and the Absolute Total Care & Wellcare New Provider Orientation document. The documented appointment access standards comply with contractual requirements with the exception of specialty emergent visits. For this category, the Provider Manual, page 8, the Member Handbook, page 14, and the Absolute Total Care & Wellcare New Provider Orientation document state the timeframe for these visits is "immediately upon presentation at service delivery site;" however, the *SCDHHS Contract, Section 6.2.3.1.5*, states the correct timeframe is "immediately upon referral." *Quality Improvement Plan: Revise the Provider Manual, page 8, the Member Handbook, page 14, and the Absolute Total Care & Wellcare New Provider Orientation document to reflect the correct timeframe for specialty emergency visits.*
2.2 The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards.	X					ATC's process for evaluating provider compliance with appointment access standards is documented in Policy SC.PRVR.15, Evaluation of the Accessibility of Services. Activities include evaluating data from member satisfaction surveys, complaints, grievances,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appeals, and site-specific telephonic or in-person surveys/audits. The 2024 Accessibility of Services Report indicates ATC assesses appointment accessibility for primary, specialty, and behavioral health care practitioners. Data was collected in Q2 2023 through an audit by a vendor. The report includes the standards used to evaluate PCP and specialty providers. All were compliant with contractual and policy standards. ATC also monitors after-hours access for PCPs, with a goal of 0% failure in compliance, and member satisfaction with provider accessibility. For the 2023 evaluation, goals were met for PCP routine and urgent care, pediatrics routine and urgent care, oncology routine and urgent care, and OB/GYN routine care. Goals were not met for PCP after-hours access and OB/GYN urgent care. Identified barriers and interventions to address the barriers were documented. Results were presented to the QIC on 8/27/24.
2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.		X				The review of the 2024 Provider & Pharmacy Directory and the online Provider Directory ("Find a Provider") revealed the online directory included all required elements. However, the PDF 2024 Provider & Pharmacy Directory did not include practice names/group affiliations and age groups. Refer to the *SCDHHS Contract, Section 3.12.3.1.1.*

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Revise the PDF 2024 Provider & Pharmacy Directory to include practice names/group affiliations and age groups for individual providers, as applicable.
2.4 The MCO conducts appropriate activities to validate Provider Directory information.	X					Data for the web-based Provider Directory is sourced from the provider data management (PDM) system and updated automatically to ensure current information. The Provider Data Excellence team updates the PDM system within 30 calendar days of receiving new information from providers or audits. The 2025 Network Development Plan states, "Absolute Total Care, to ensure network compliance, reviews and evaluates our printed and online directory as well as conducts secret shopper exercises to monitor for network accuracy. In addition, we continue working with VEDA Risk Solutions, as well as monthly internal audits to confirm all provider directory related information. We have incorporated not only the directory team on these audits, but other departments to allow the company to work as one and have our groups updated in a timely manner. These activities allow the health plan to verify the accuracy of the provider directory."
2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.			X			As part of the annual EQR process for ATC, a provider access study was performed focusing on primary care providers. A list of current providers was given to Constellation by ATC, from which a population of 2,012 unique PCPs was found. A sample of 180 providers was randomly selected from this population for the Access Study. Attempts were made to contact

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						these providers to ask a series of questions regarding member access to the providers. For the Telephone Provider Access Study conducted by Constellation, 105 out of 172 calls were successfully answered when omitting eight calls answered by personal or general voicemail messaging services. This equates to a 61% successful contact rate. When compared to last year's results of 67%, this is a non-significant decline in the successful contact rate. For the 67 calls that were not answered successfully, most were due to the provider no longer being active at that location (n = 40, 60%). The next most common reason was no answer or wrong number (n = 18, 27%), followed by the caller being informed that the provider was not a PCP (n = 7, 10%). The least common reason for an unsuccessful call was the caller getting immediate notification that the provider was not accepting new patients and the respondent ending the call (n = 2, 3%). Of 105 providers successfully contacted, 71 (68%) accepted ATC and 34 (32%) did not accept ATC. Of the 71 who are accepting ATC, 51 (72%) are accepting new patients and 20 (28%) are not accepting new patients. A routine appointment was available within the contractual requirement of 30 days for 16 (31%) of the 51 that are accepting new patients and outside the required timeframe for 18 (35%). A

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						total of 17 of the 51 calls (33%) were unable to obtain an appointment date due to the provider requesting more information such as medical records or insurance number of the member. *Quality Improvement Plan: Provide documentation on outreach to providers and the procedures that are in place to update provider contact information, and panel status for providers.*
2.6 The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The State has documented time/distance requirements for primary care, OB/GYN, and specialty providers. The methods ATC uses for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. The ISCA evaluation confirmed that the organization and its information systems effectively meet the State's requirements. The organization consistently reviews and revises its policies to uphold data and system security. ATC performs internal audits to ensure compliance with these requirements and routinely engages external auditors to validate its system controls.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	X					ATC conducts orientation for all newly contracted providers, ancillary providers, and hospitals who are not part of an existing in-network group or facility to ensure that providers and their staff can operate effectively within ATC's network. The orientation is

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						conducted within 30 business days of the provider becoming active with ATC. The orientation may be conducted in person or virtually. Orientation materials include a Provider Manual, Provider Presentation Handout, Quick Reference Guide, Member Connections Referral Form, Notification of Pregnancy Form, Utilization Management Prior Authorization Form, and Early and Periodic Screening, Diagnostic and Treatment Tool. This process is documented in Policy SC.PRVR.13, Provider Orientations. The Absolute Total Care & Wellcare New Provider Orientation document covers Medicaid, balance billing, no-cost interpreter/oral translation services, features of the website and the secure provider portal, access and availability standards, claims, network development and participation, credentialing rights, cultural competency, quality improvement, and the Start Smart for Your Baby Program. It also provides the names and contact information for the Provider Relations team and hyperlinks to provider resources on the website. The Provider Manual is an additional source of information for network providers.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				The Provider Manual does not provide information about benefits/coverage for communicable disease services and post-stabilization services. *Quality Improvement Plan: Revise the Provider Manual to include information about benefits/coverage for communicable disease services and post-stabilization services. Refer to SCDHHS Contract, Section 4 (Core Benefits and Services, Managed Care Coverage table).*
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention, and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies, and procedures.	X					Ongoing provider education is conducted through the following activities: • Routine face-to-face visits by Provider Engagement Administrators • Facility participation in quarterly Joint Operations Committee meetings • Visits with ancillary providers as needed • Virtual or face-to-face regional provider training sessions
II D. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health and clinical practice guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy SC.QI.08, Clinical and Preventive Practice Guidelines, describes the procedures for development, adoption, and revision of CPGs and PHGs. Board certified providers review and make recommendations about the guidelines under consideration through the QIC. When recognized source guidelines cannot be identified, the Centene Clinical Policy Committee is consulted for assistance in guideline development. Guidelines are updated as needed upon significant new scientific evidence or changes in national standards. The guidelines are reviewed and approved annually by the QIC.
2. The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members.	X					ATC disseminates the PHGs and CPGs to providers based on specialty. The guidelines are available to all providers upon request and are available on ATC's website.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The Provider Manual includes information describing the review and adoption process for CPGs and PHGs and encourages providers to use the guidelines as a basis for developing personalized treatment plans. Providers are informed that ATC may measure compliance with the guidelines HEDIS measure monitoring and medical record audits. The Provider Manual refers the reader to ATC's website to access the guidelines. The hyperlink to the Sickle Cell Disease guideline on ATC's website returns an error message that "The page you're looking for was not found." It does not redirect the user to the correct website. *Recommendation: Update the website to provide the correct hyperlink to the Sickle Cell Disease guideline.*
3. The guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					ATC collects data annually to improve collaboration between medical and behavioral health providers for six key areas, including information exchange, appropriate diagnosis and treatment, psychotropic medication use, treatment access for co-existing disorders, preventive programs, and special needs for serious mental illness. The resulting data is reviewed and analyzed to identify at least two improvement opportunities and develop appropriate interventions. ATC measures the effectiveness of the interventions annually. These processes are documented in Policy CC.QI.10, Continuity & Coordination Between Medical and Behavioral Health Care. The 2024 Quality Program Description states ATC monitors and addresses opportunities to improve continuity and coordination of care by collecting data on member movement between practitioners, member movement across health care settings, HEDIS measures, member, and provider satisfaction survey results, etc.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The 2023 Quality Improvement Program Evaluation includes a detailed breakdown of the monitoring activities for 2023 as well as opportunities for improvement, the effectiveness of previously implemented interventions, and new interventions.
II F. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Standards for medical record documentation and processes for assessing provider compliance with the standards are included in Attachment A of Policy SC.QI.13, Medical Record Review. Standards for medical record documentation are also included in the Provider Manual and on the Medical Record Documentation Standards tool found on ATC's website.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					The Medicaid Medical Record Review 2024 Annual Audit Report was presented during the August 2024 QIC meeting. A total sample of 2,447 practitioners was identified, and 71 practitioners were selected for the medical record review. 355 records were audited across the 71 practitioners. All practitioners received a total passing score of 80% or greater, with an overall score of 93.7%. This was a 0.5

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						percentage-point increase from the previous year. No practitioners required follow-up action.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

C. Member Services

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

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

Members are informed of their rights and responsibilities in Policy SC.BO.ABR.01, Member Rights and Responsibilities, the Member Handbook, in newsletters, and on the website. The list of member rights is consistently documented across the Member Handbook, the Provider Manual, and on ATC's website.

Members are informed in the Member Handbook how to access the provider listing on ATC's website or request a Provider Directory. The Member Handbook describes benefits and health plan services. Covered and excluded services are outlined in the Member Handbook's benefit grid. However, during the onsite, it was discussed that the Member Handbook does not contain information regarding the services provided through the Developmental Evaluation Centers (DECs) that became effective on 2/1/24.

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

Member materials are available in alternate formats and languages as needed to meet member needs. Member materials are written at a sixth-grade reading level. The Member Handbook provides information about the availability of and how to request translated materials and interpreter/language services at no cost.

The Member Services Call Center is available via a toll-free telephone number, toll-free fax, and TTY from 8:00 a.m. to 6:00 p.m., Monday through Friday. Policy SC. MBRS.28, Telephone Responsiveness and Call Center Performance, defines performance standards for speed of answer, average hold time, and the disconnect rate for incoming calls.

The 2024 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program Description includes the goals, objectives, and guidelines for the EPSDT Program. ATC uses various data sources to identify EPSDT eligible members, monitors compliance with the provision of EPSDT services, and conducts outreach to educate and follow-up with members to improve EPSDT

screening rates. The Member Handbook describes available lifestyle management and chronic conditions programs. However, no information was included regarding how to access these programs. It was recommended onsite to include additional information for member access options.

Member Satisfaction Survey

ATC contracts with a vendor, Press Ganey, for both the child and adult surveys. For Measure Year 2023, the adult response rate was 11.9%, an improvement over the previous response rate of 11.5%. For year over year trending, the findings showed improvement in getting needed care, ease of filling out forms, and coordination of care. The largest decline occurred for the rating of specialists. A decline of 13.7 percentage points was noted.

The child response rate was 9.3%, a slight decline from last year's response rate of 10.0%. For year over year trending, improvement occurred for getting needed care, customer service, getting care quickly, and coordination of care. The largest decline occurred for rating of health care (-7.9 percentage points).

The Children with Chronic Conditions (CCC) response rate was 8.8%, a decline from last year's response rate of 9.7%. For the CCC population, improvement occurred for getting care quickly, access to medicines, and those reporting that the child has a personal doctor or nurse who knows them. The largest decline occurred for coordination of care (-13.7 percentage points).

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results, while accessible on the website, were challenging to locate due to the document title not clearly indicating their presence. Constellation recommends enhancing accessibility by featuring the CAHPS results prominently in a newsletter, email, or fax blast, or placing the results in a more visible and user-friendly location on the website for providers.

Grievances

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

Policy SC.MM.11, Member Grievances, the Member Handbook, Provider Manual, and the website provide the steps for filing verbal and written grievances. Steps for appointing an authorized representative, if needed, are also provided. Appropriate timeframes are detailed in policy for grievance acknowledgement, extensions if needed, and resolution.

Constellation reviewed a sample of grievance files and found all were resolved within the 90-day timeframe. One grievance was not acknowledged in a timely manner and was closed with 67 days remaining due to missing information and member contact. During the onsite, it was recommended to review and revise processes and retrain staff to ensure consistent steps are

taken for locating accurate contact information for members when additional information is needed to process a grievance.

The 2024 EQR found that 100% of the Member Services standards were scored as "Met."

Figure 5: Member Services Findings

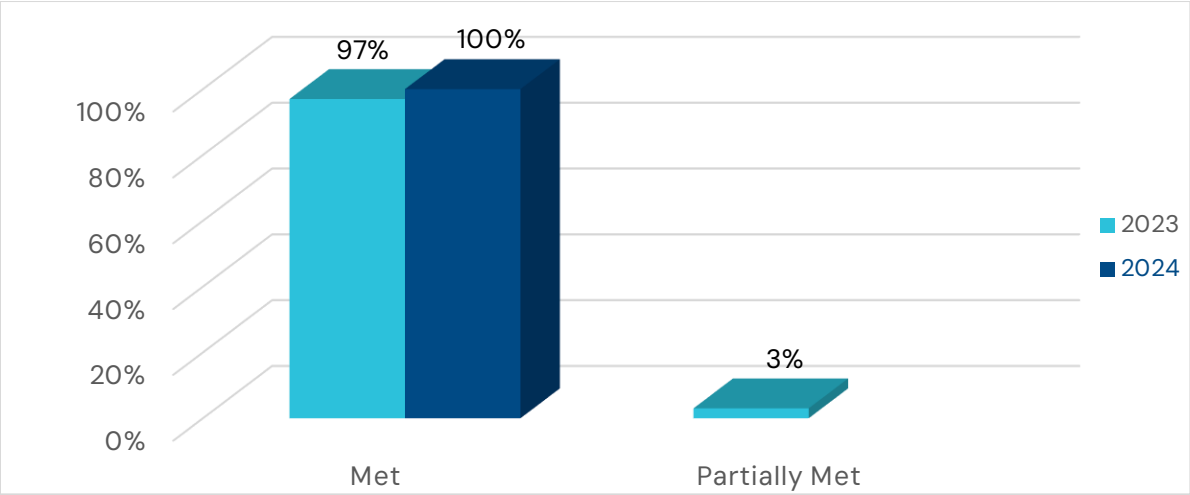


Table 16: Member Services Comparative Data

Section	Standard	2023 Review	2024 Review
Member Rights and Responsibilities	Member rights include, but are not limited to, the right: To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 17: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
The sample of grievance files reviewed were all resolved within the 90-day timeframe.		✓	

Table 18: Member Services Weaknesses

Weakness	Recommendation	Quality	Timeliness	Access to Care
The Member Handbook does not contain information specific to the Developmental Evaluation Centers and services effective 2/1/24.	*Recommendation: Revise the Member Handbook to include information that clearly indicates services provided through the Developmental Evaluation Centers.*			✓
No information is included in the Member Handbook for members to access ATC's lifestyle management and chronic conditions programs.	*Recommendation: Revise the Member Handbook to include information on ways for members to access lifestyle management and chronic conditions programs.*			✓
Results of the member satisfaction surveys were provided after the onsite in a PDF document that is available on ATC's website. However, the title of the document does not clearly indicate that it contains the CAHPS results.	*Recommendation: Consider enhancing accessibility by featuring the CAHPS results prominently in a newsletter, email, or fax blast, or placing the results in a more visible and user-friendly location on the website for providers.*	✓		
One grievance was not acknowledged timely and was closed with 67 days remaining due to missing information and member contact.	*Recommendation: Review and revise processes and retrain staff to ensure consistent steps are taken to locate accurate contact information for members when additional information is needed to process a grievance. .*	✓		

III. MEMBER SERVICES

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Member rights are documented in Policy SC.BO.ABR.01, Member Rights and Responsibilities, the Member Handbook, and the website.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					
1.1 Benefits and services included and excluded in coverage;						Covered and excluded services are outlined in the Member Handbook's benefit grid. However, during the onsite, it was discussed that the Member Handbook does not contain information specific to the Developmental Evaluation Centers and services effective 2/1/24. *Recommendation: Revise the Member Handbook to include information that clearly indicates services provided through the Developmental Evaluation Centers.*
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						The benefit grid in the Member Handbook details copayment amounts, coverage requirements and limitations, and maximum benefits for services.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Information specific to services that require prior authorization is located in the Member Handbook.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						
1.7 Policies and procedures for accessing specialty care;						While PCP referrals are not required for members to seek specialty care from network providers, information is provided in the Member Handbook instructing members to consult with their PCP for assistance.
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Members are informed of ways to obtain medications and medical equipment in the Pharmacy section of the Member Handbook. Descriptions of processes for obtaining prescription medications, accessing the Preferred Drug List, locating participating

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						pharmacies, copayments, the limitation on the supply of medications, and prior authorization processes are clearly described.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						The Member Handbook provides information about accessing the Nurse Advice Line. The Member Handbook describes services available through the Member Services Department as well as contact information and hours of operation.
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;						
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					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
5. The MCO maintains, and informs members how to access, a toll-free vehicle for 24-hour member access to coverage information from the MCO.	X					
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					Policy SC.ELIG.01, PCP Assignment, and the Member Handbook explain that when members do not select a PCP, they are auto-enrolled into ATC without a PCP and the auto-assignment process is started. The auto-assignment will allow members to be assigned to providers located geographically close to their home and/or a provider who best meets their needs. If the member selects a PCP, the PCP assignment is effective immediately, and a new ID card is sent to the member.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC.ELIG.11, MCO Initiated Disenrollment, defines the reasons that members may request disenrollment. The policy states that plan-initiated disenrollment requests must be directed to Healthy Connections Choices in writing.
III D. Preventive Health and Chronic Disease Management Education						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members are informed in the Member Handbook about the availability of lifestyle management and chronic conditions programs which provide health coaching, health assessment, and an incentive management guide to encourage healthy living. However, no information is included in the Member Handbook for members to access ATC's lifestyle management and chronic conditions programs. *Recommendation: Revise the Member Handbook to include information on ways for members to access lifestyle management and the chronic conditions programs.*
2. The MCO identifies children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					ATC contracts with Press Ganey, a certified vendor, to conduct the adult and child surveys.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Press Ganey summarizes and details all the results from the adult and child surveys.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					The August 2024 QIC minutes noted member satisfaction workgroup activity to address quality issues identified in the member satisfaction surveys.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Results of the member satisfaction surveys were provided after the onsite in a PDF document that is available on ATC's website. However, the title of the document does not clearly indicate that it contains the CAHPS results.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Consider enhancing accessibility by featuring the CAHPS results prominently in a newsletter, email, or fax blast, or placing the results in a more visible and user-friendly location on the website for providers.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					The August 2024 QIC Q3 minutes include results of the member satisfaction survey and identified areas for quality improvement.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC.MM.11, Member Grievances, the Member Handbook, Provider Manual, and the website describe ATC's process for the receipt, review, and resolution of member grievances.
1.1 The definition of a grievance and who may file a grievance;	X					The term grievance is defined throughout member and provider materials as an "…expression of dissatisfaction about any matter other than an Adverse Benefit Determination."
1.2 Procedures for filing and handling a grievance;	X					ATC's processes for handling verbal or written grievances filed by the member or an authorized representative are clearly described.
1.3 Timeliness guidelines for resolution of a grievance;	X					Policy SC.MM.11, Member Grievances, indicates that grievances will be acknowledged via letter within 5 calendar days from the date of receipt, with resolution within 90 calendar days, and a 14-day extension if needed.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.	X					Constellation reviewed a sample of grievance files and found all were resolved within the 90-day timeframe. One grievance was not acknowledged in a timely manner and was closed with 67 days remaining due to missing information and member contact. *Recommendation: Review and revise processes and retrain staff to ensure consistent steps are taken to locate accurate contact information for members when additional information is needed to process a grievance.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

D. Quality Improvement

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

The 2024 Quality Program Description for ATC outlines the health plan's commitment to continuous quality improvement across all aspects of the organization. The program integrates quality assurance, management, and improvement into daily operations, with defined performance metrics and accountability to the Quality Improvement Committee and Board of Directors. The primary goal is to improve members' health status by supporting providers and ensuring care meets professional standards. The purpose and scope of the program focuses on improving health outcomes, healthcare processes, and member/provider experience across all demographic groups and care settings. The program description includes the program's structure, staffing, and resources. The Program is governed by the Board of Directors, with the QIC overseeing various subcommittees and quality activities. The program description is reviewed and approved annually by the QIC and Board of Directors to ensure it meets the evolving needs of members and regulatory requirements.

The Quality Work Plan is a key component of ATC's continuous quality improvement cycle. The Quality Work Plan is developed annually and reflects the ongoing progress of quality activities and includes recommendations for improvements based on the annual Program Evaluation. ATC provided the 2023 and 2024 Quality Improvement (QI) work plans. Both documents clearly define the activities completed or to be completed by each department and supporting committees throughout the year. The work plans included the yearly planned activities, objectives, timeframe for completion of each activity, responsible party, and updates. The Work Plan is reviewed by the Quality Improvement Committee on a quarterly basis.

The QIC is the senior leadership committee, accountable to the Board of Directors, that reviews and monitors all clinical quality and service functions of the health plan. The QIC is composed of senior staff and physicians who are voting members, along with support staff. The Chief Medical Director chairs the committee. Membership includes network practitioners specializing in pediatrics, OB/GYN, psychiatry, and family medicine. A quorum for the committee requires a minimum of three members, including the Committee Chair, one health plan staff, and one external practitioner. The QIC meets quarterly, with additional meetings scheduled as needed, and reports its activities, findings, recommendations, actions, and results to the Board of Directors at least annually.

Providers receive information about their performance through several methods. ATC offers population health management reporting designed to support providers in delivering timely, efficient, and evidence-based care. This includes care gap reporting at member and population levels and exportable patient data to support member outreach. The Provider Analytics Tool

supports providers participating in value-based programs by identifying performance opportunities and assisting with population health management initiatives. It includes key performance indicators, cost and utilization data, emergency room cost and utilization data, pharmacy comparisons, and value-based contracting performance summaries. Providers may receive interventions to address performance that is out of range from their peers. This can include provider education, sharing of best practices, assistance with barrier analysis, development of corrective action plans, and ongoing medical record reviews.

ATC tracks Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services through a comprehensive program designed to ensure that members up to the age of 21 receive preventive health care and services. ATC performs health risk screenings for new members within 90 days of enrollment to assess their needs, including EPSDT services. The health plan collects, analyzes, and regularly reports data on EPSDT services to monitor compliance with preventive health guidelines and identify any gaps in care.

Annually, ATC evaluates the effectiveness of the QI Program and reports the results to the Board of Directors. This annual evaluation includes a comprehensive review and analysis of the program's effectiveness over the past year. The 2023 Quality Improvement Program Evaluation included an assessment of the QI program's impact on improving clinical practices and member care, resource adequacy, a summary of completed and ongoing quality activities addressing clinical care and service quality, performance trends, interventions, and recommendations. The evaluation findings are used to refine the QI Program, ensuring continuous improvement and alignment with ATC's strategic goals and regulatory requirements.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation conducted a validation review of the performance measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. ATC uses an NCQA Licensed Organization for calculation of HEDIS® rates. Rates were audited by Attest Health Care Advisors. The performance measure validation found that ATC was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

As part of the review, Constellation examined the roadmap, the data sources, the audit report, and conducted a trend analysis to assess for substantial declines or increases in the rates. All relevant HEDIS performance measures (PMs) for the current measure year (2023), the previous measure year (2022), and the change from 2022 to 2023 are reported in *Table 19: HEDIS Performance Measure Results*. Rate changes shown in green indicate a substantial improvement (>10%) and the rates shown in red indicate a substantial decrease (>10%).

Table 19: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)			
BMI Percentile	73.48%	76.89%	3.41%
Counseling for Nutrition	61.80%	65.94%	4.14%
Counseling for Physical Activity	57.42%	63.75%	6.33%
Childhood Immunization Status (CIS)			
DTaP	65.21%	66.91%	1.70%
IPV	82.97%	82.73%	-0.24%
MMR	82.97%	84.43%	1.46%
HiB	80.05%	78.83%	-1.22%
Hepatitis B	82.00%	84.91%	2.91%
VZV	82.73%	83.94%	1.21%
Pneumococcal Conjugate	69.83%	70.32%	0.49%
Hepatitis A	83.21%	83.70%	0.49%
Rotavirus	70.07%	68.86%	-1.21%
Influenza	30.17%	23.84%	-6.33%
Combination #3	59.61%	62.29%	2.68%
Combination #7	53.53%	55.47%	1.94%
Combination #10	21.41%	18.49%	-2.92%
Immunizations for Adolescents (IMA)			
Meningococcal	70.07%	76.89%	6.82%
Tdap/Td	83.70%	86.37%	2.67%
Combination #1	70.07%	76.89%	6.82%
Combination #2	29.93%	29.93%	0.00%
Human Papillomavirus Vaccine for Female Adolescents (HPV)	30.17%	30.66%	0.49%
Lead Screening in Children (LSC)	60.30%	63.48%	3.18%
Breast Cancer Screening (BCS)	52.18%	53.92%	1.74%
Cervical Cancer Screening (CCS)	56.93%	57.47%	0.54%
Colorectal Cancer Screening (COL)	36.77%	41.02%	4.25%
Chlamydia Screening in Women (CHL)	61.17%	61.48%	0.31%
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (CWP)	80.32%	86.66%	6.34%
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	22.83%	24.07%	1.24%
Pharmacotherapy Management of COPD Exacerbation (PCE)			
Systemic Corticosteroid	70.16%	72.08%	1.92%

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Bronchodilator	79.76%	79.51%	-0.25%
Asthma Medication Ratio (AMR *Total*	62.17%	59.33%	-2.84%
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (CBP)	56.69%	59.85%	3.16%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	75.34%	47.22%	-+28.12%
Statin Therapy for Patients With Cardiovascular Disease (SPC)			
Received Statin Therapy - Total	80.18%	81.02%	0.84%
Statin Adherence 80% - Total	57.64%	54.57%	-3.07%
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	3.10%	1.46%	-1.64%
Cardiac Rehabilitation - Engagement1 (Total)	5.75%	2.91%	-2.84%
Cardiac Rehabilitation - Engagement2 (Total)	5.75%	2.91%	-2.84%
Cardiac Rehabilitation - Achievement (Total)	2.65%	0.49%	-2.16%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (CDC)			
HbA1c Poor Control (>9.0%)	39.66%	30.41%	-9.25%
HbA1c Control (<8.0%)	51.82%	61.07%	9.25%
Eye Exam (Retinal) Performed (EED)	42.34%	44.77%	2.43%
Blood Pressure Control for Patients With Diabetes (BPD)	56.69%	69.34%	12.65%
Kidney Health Evaluation for Patients With Diabetes (KED)	25.81%	36.04%	10.23%
Statin Therapy for Patients With Diabetes (SPD)			
Received Statin Therapy	63.26%	65.64%	2.38%
Statin Adherence 80%	51.65%	51.23%	-0.42%
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (Total)	23.06%	25.10%	2.04%
Antidepressant Medication Management (AMN)			
Effective Acute Phase Treatment	45.03%	45.36%	0.33%
Effective Continuation Phase Treatment	28.59%	28.41%	-0.18%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)			
Initiation Phase	46.10%	47.36%	1.26%
Continuation and Maintenance (C&M) Phase	59.91%	61.26%	1.35%
Follow-Up After Hospitalization for Mental Illness (FUH)			
Total - 30-Day Follow-Up	62.96%	59.34%	-3.62%
Total - 7-Day Follow-Up	42.41%	36.19%	-6.22%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)			
Total - 30-Day Follow-Up	52.76%	50.11%	-2.65%
Total - 7-Day Follow-Up	40.56%	37.50%	-3.06%
Diagnosed Substance Use Disorders (DSU)			

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Diagnosed Substance Use Disorders - Alcohol (Total)	1.76%	1.70%	-0.06%
Diagnosed Substance Use Disorders - Opioid (Total)	1.46%	1.56%	0.10%
Diagnosed Substance Use Disorders - Other (Total)	2.93%	2.89%	-0.04%
Diagnosed Substance Use Disorders - Any (Total)	4.89%	4.95%	0.06%
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)			
Total - 30-Day Follow-Up	34.97%	33.90%	-1.07%
Total - 7-Day Follow-Up	21.39%	19.18%	-2.21%
Follow-Up After Emergency Department Visit for Substance Abuse (FUA)			
Total - 30-Day Follow-Up	26.07%	24.01%	-2.06%
Total - 7-Day Follow-Up	17.38%	15.97%	-1.41%
Pharmacotherapy for Opioid Use Disorder Total (POD)	35.31%	32.64%	-2.67%
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD)	75.76%	78.50%	2.74%
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	67.59%	70.71%	3.12%
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	*80.00%	*85.19%	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	64.36%	64.71%	0.35%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)			
Blood glucose testing - Total	51.71%	57.22%	5.51%
Cholesterol Testing - Total	30.23%	38.65%	8.42%
Blood glucose and Cholesterol Testing - Total	28.14%	35.46%	7.32%
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	0.75%	0.49%	-0.26%
Appropriate Treatment for Children With URI (URI)			
Total	87.90%	87.68%	-0.22%
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (AAB)			
Total	56.45%	52.82%	-3.63%
Use of Imaging Studies for Low Back Pain (IBP)	69.37%	67.40%	-1.97%
Use of Opioids at High Dosage (HDO)	3.82%	3.83%	0.01%
Use of Opioids From Multiple Providers (UOP)			
Multiple Prescribers	17.38%	18.90%	1.52%
Multiple Pharmacies	1.24%	2.60%	1.36%
Multiple Prescribers and Multiple Pharmacies	1.01%	1.24%	0.23%
Risk of Continued Opioid Use (COU)			
Total - >=15 Days covered	3.58%	2.81%	-0.77%
Total - >=31 Days covered	2.12%	2.10%	-0.02%

Measure/Data Element	Measure Year 2022	Measure Year 2023	Percentage Point Difference
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (AAP)			
Total	72.46	76.73%	4.27%
Initiation and Engagement of AOD Dependence Treatment (IET)			
Initiation of AOD Treatment: Total	42.34%	42.54%	0.20%
Engagement of AOD Treatment: Total	10.67%	6.47%	-4.20%
Prenatal and Postpartum Care (PPC)			
Timeliness of Prenatal Care	84.43%	83.45%	-0.98%
Postpartum Care	71.29%	76.40%	5.11%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)			
Total	58.97%	55.73%	-3.24%
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
First 15 Months	53.35%	55.21%	1.86%
15 Months-30 Months	65.07%	69.11%	4.04%
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	41.67%	48.72%	7.05%
Antibiotic Utilization for Respiratory Conditions (AXR)			
Antibiotic Utilization for Respiratory Conditions (Total)	22.93%	30.31%	7.38%

Note: NR = Not Reportable; NA= Not Applicable due to missing data or small denominator
*Unreliable rate due to small denominator
⁺Break in trending is recommended due to changes to the exclusion criteria.

As noted in Table 19, one measure declined. Persistence of Beta-Blocker Treatment After a Heart Attack declined by 28.12%. However, the National Committee for Quality Assurance (NCQA) recommends a break in trending due to changes in the exclusion criteria. Two measures improved substantially: Blood Pressure Control for Patients with Diabetes(<140/90 mm Hg) improved by 12.65% and Kidney Health Evaluation for Patients With Diabetes improved by 10.23%.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

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

ATC submitted three PIPs for validation. Topics included Hospital Readmissions, Timeliness of Prenatal Care, and Adult Access to Preventive Health Care. All the PIPs scored in the "High Confidence in Reported Results" range as noted in the following tables. A summary of each PIP's status and interventions is also included.

Table 20: Hospital Readmissions PIP

Hospital Readmissions	
The Hospital Readmissions PIP aims to reduce the annual rate of readmissions within 30 days for 18- to 64-year old patients. The readmissions PIP has three measurement periods. The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge declined from 15.5% in 2022 to 15.3% in 2023. The benchmark is set at 15%. This PIP is retiring.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• Transition of Care team assesses members upon discharge and reviews the discharge summary, assists members with scheduling appointments within 7 days of discharge, and forwards referrals for case management to ensure members have the resources and services to prevent readmissions. • Post Hospital Outreach (PHO) Team contacts facilities to assist with discharge planning prior to member's discharge. The PHO team notifies the PCP of the admission for all physical health admissions. • For members with 10 or more medications, outreach is made to the PCP to reconcile medications. Once all required information is obtained, the Case Manager forwards the case to the pharmacist to review and reconcile with the member and faxes back to the PCP. • Multidisciplinary readmissions team, which includes members from Medical Affairs, Care Management, Utilization Management, and Quality Improvement, meets quarterly to review specific members with multiple readmissions; those members are reviewed in Care Management rounds to discuss interventions for members. Utilization Management Manager pulls a daily report of discharges and prioritizes members needing home health or durable medical equipment to ensure those members have all needs met.	

Table 21: Timeliness of Prenatal Care PIP

Timeliness of Prenatal Care
The timeliness of prenatal care clinical PIP was initiated in 2023 using a baseline rate from measure year 2022 HEDIS rate. As of this review, only the baseline rate was available. The hybrid rate was 84.43% with a benchmark of 88.32%.

Timeliness of Prenatal Care	
Previous Validation Score	Current Validation Score
N/A	93/93=100% High Confidence in Reported Results
Interventions	
• Tablets are distributed to women in rural areas to allow them to participate in telehealth services. • The pay-for-performance incentives were expanded to encourage adherence to prenatal HEDIS recommendations. • Disparity analysis is used to identify areas where disparities exist to improve health equity and assist those members with accessing prenatal care.	

Table 22: Adult Access to Preventive Health Care PIP

Adult Access to Preventive Health Care (AAP)	
The aim for the Adult Access to Preventive Health Care PIP is to improve preventive care for adults 20 and older. The AAP PIP showed a decline in the annual rate from 2021 (78.18%) to 2022 (72.46%). The 2023 measure year rate in the quarterly quality assessment document showed a rate of 76.73%.	
Previous Validation Score	Current Validation Score
80/80=100% High Confidence in Reported Results	74/75=99% High Confidence in Reported Results
Interventions	
• Re-educate member outreach staff regarding the availability of telehealth as an option for health care visits, so they are well-versed to assist members with scheduling appointments and alleviating fears of COVID-19 as a cause for members not receiving needed care. • Member Services and Operations teams provided educational/training information via quarterly Member Advisory Committee Meetings, Member Newsletters, and New Member Welcome Packets to improve member knowledge and understanding of appointment availability standards. • Member outreach staff educate members on the importance of seeing their provider to receive recommended services. • Educate providers on required availability standards and the value of offering telehealth visits during quality staff provider visits and provider Town Hall meetings. • Provider Relations provided educational/training information via quarterly Provider Town Hall Meetings, Provider Orientations, Provider Newsletters, and during office visits related to the standards and best practices for appointment accessibility. • Eliza application for scheduling appointments and member outreach. • Well Woman Proactive Outreach Manager (POM) calls deployed to remind women to schedule needed services. Roll back option added to current static POM calls for adult annual wellness visits to give members the option to get assistance with scheduling appointments.	

There was no documented improvement in the Adult Access to Preventive Health Care PIP. Constellation offered the recommendation noted in *Table 23: PIP Recommendation*.

Table 23: PIP RECOMMENDATION

Project	Section	Reason	Recommendation
Adult Access to Preventive Health Care: Non-Clinical	Was there any documented, quantitative improvement in processes or outcomes of care?	A decline in the annual rate from 2021 (78.18%) to 2022 (72.46%). The 2023 measure year rate in the quarterly quality assessment document showed a rate of 76.73%.	Continue efforts to educate members on the importance of attending preventive care appointments using outreach and at events.

Details of the validation of the PMs and PIPs can be found in the *EQR Validation Worksheets, Attachment 3*. ATC met all the requirements in the Quality Improvement section for this EQR as noted in Figure 6.

Figure 6: Quality Improvement Findings

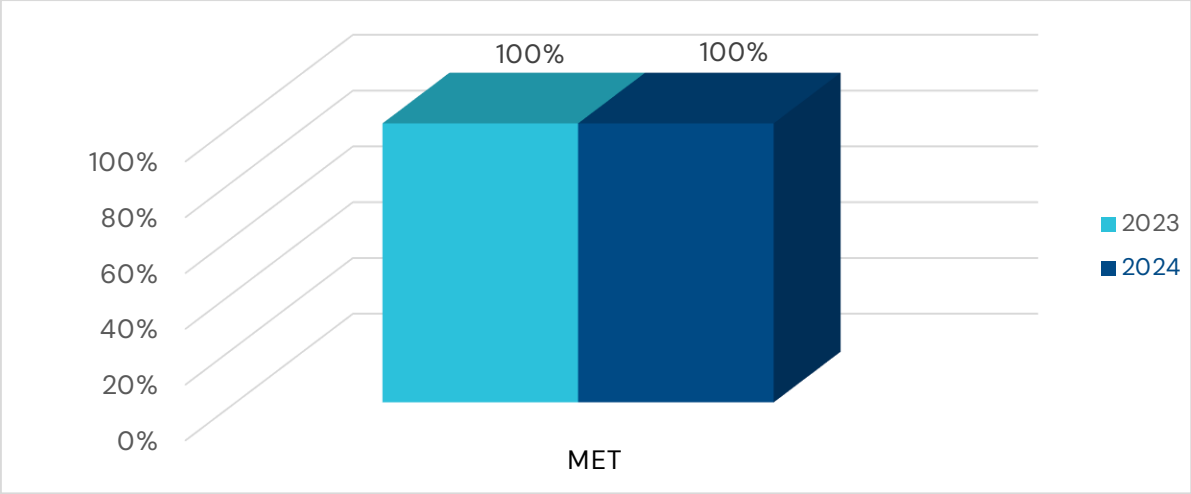


Table 24: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
The QI Program addresses a wide range of areas including preventive health, emergency care, chronic care, behavioral health, and social determinants of health. It integrates quality improvement activities across all departments and care settings, ensuring a holistic approach to member health and service quality.	✓		

Strengths	Quality	Timeliness	Access to Care
ATC utilizes advanced data analytics and health information systems to monitor, analyze, and report on performance, enabling targeted and measurable interventions.	✓		
All three PIPs scored in the High Confidence range.	✓		

Table 25: Quality Improvement Weaknesses

Weakness	Recommendation	Quality	Timeliness	Access to Care
The Adult Preventive Care PIP showed a decline from the previous year's rate.	*Recommendation: Continue efforts to educate members on the importance of attending preventive care appointments using outreach and at events.*	✓		

IV. QUALITY IMPROVEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope, and methodology directed at improving the quality of health care delivered to members.	X					The 2024 Quality Program Description for ATC outlines the health plan's commitment to continuous quality improvement across all aspects of the organization. The program integrates quality assurance, management, and improvement into daily operations, with defined performance metrics and accountability to the QIC and Board of Directors. The primary goal is to improve members' health status by supporting providers and ensuring care meets professional standards. The purpose and scope of the program focuses on improving health outcomes, healthcare processes, and member/provider experience across all demographic groups and care settings. The program description includes the program's structure, staffing, and resources. The Program is governed by the Board of Directors, with the QIC overseeing various subcommittees and quality activities. The program description is reviewed and approved annually by the QIC and Board of Directors to ensure it meets the evolving needs of members and regulatory requirements.
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that	X					The Utilization Management Committee performs routine assessments of utilization data to identify potential over- and under-utilization issues or practices. Data analysis is conducted using various

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
demonstrate potential health care delivery problems.						sources such as medical service encounter data and pharmacy reporting to identify patterns of potential or actual inappropriate utilization of services. Overall, utilization data plays a crucial role in ATC's efforts to monitor, assess, and improve the quality of care and services provided to its members.
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					The Quality Work Plan is a key component of ATC's continuous quality improvement cycle. The Quality Work Plan is developed annually, reflects the ongoing progress of quality activities, and includes recommendations for improvements based on the annual Program Evaluation. ATC provided the 2023 and 2024 QI work plans. Both documents clearly define the activities completed or to be completed by each department and supporting committees throughout the year. The work plans included the yearly planned activities, objectives, timeframe for completion of each activity, responsible party, and updates. The Work Plan is reviewed by the Quality Improvement Committee on a quarterly basis.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The QIC is the senior leadership committee, accountable to the Board of Directors, that reviews and monitors all clinical quality and service functions of the health plan.
2. The composition of the QI Committee reflects the membership required by the contract.	X					The QIC is composed of senior staff and physicians who are voting members, along with support staff. The Chief Medical Director chairs the committee. Membership includes network practitioners specializing in pediatrics, OB/GYN, psychiatry, and family medicine. A quorum for the committee

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requires a minimum of three members, including the Committee Chair, one health plan staff, and one external practitioner.
3. The QI Committee meets at regular quarterly intervals.	X					The QIC meets quarterly, with additional meetings scheduled as needed, and reports its activities, findings, recommendations, actions, and results to the Board of Directors at least annually.
4. Minutes are maintained that document proceedings of the QI Committee.	X					
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					As part of the review, Constellation examined the roadmap, the data sources, and the audit report, and conducted a trend analysis to assess for substantial declines or increases in the rates. One measure, Persistence of Beta-Blocker Treatment After a Heart Attack, declined by 28.12%. However, NCQA recommends a break in trending due to changes in the exclusion criteria. Two measures improved substantially: Blood Pressure Control for Patients with Diabetes(<140/90 mm Hg) by 12.65% and Kidney Health Evaluation for Patients With Diabetes by 10.23%. ATC met the performance validation requirements.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					ATC submitted three PIPs for validation. Topics included Hospital Readmissions, Timeliness of Prenatal Care, and Adult Access to Preventive Health Care.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					All the PIPs scored in the "High Confidence in Reported Results" range and met the validation requirements. There was no documented improvement in the Adult Access to Preventive Health Care PIP. *Recommendation: Continue efforts to educate members on the importance of attending preventive care appointments using outreach and at events.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Providers receive information about their performance through several methods. ATC offers population health management reporting designed to support providers in delivering timely, efficient, and evidence-based care. This includes care gap reporting at member and population levels and exportable patient data to support member outreach. The Provider Analytics Tool supports providers participating in value-based programs by identifying performance opportunities and assisting with population health management initiatives. It includes key performance indicators, cost and utilization data, emergency room cost and utilization data, pharmacy comparisons, and value-based contracting performance summaries. Providers may receive interventions to address

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performance that is out of range from their peers. This can include provider education, sharing of best practices, assistance with barrier analysis, development of corrective action plans, and ongoing medical record reviews.
3. The MCO tracks provider compliance with						
3.1 Administering required immunizations;	X					
3.2 Performing EPSDTs/Well Child Visits.	X					ATC tracks EPSDT services through a comprehensive program designed to ensure that members up to the age of 21 receive preventive health care and services. ATC performs health risk screenings for new members within 90 days of enrollment to assess their needs, including EPSDT services. The health plan collects, analyzes, and regularly reports data on EPSDT services to monitor compliance with preventive health guidelines and identify any gaps in care.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Annually, ATC evaluates the effectiveness of the QI Program and reports the results to the Board of Directors. This annual evaluation includes a comprehensive review and analysis of the program's effectiveness over the past year. The 2023 Quality Improvement Program Evaluation included an assessment of the QI program's impact on improving clinical practices and member care, resource adequacy, a summary of completed and ongoing quality activities addressing clinical care and service quality, performance trends,

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						interventions, and recommendations. The evaluation findings are used to refine the QI Program, ensuring continuous improvement and alignment with ATC's strategic goals and regulatory requirements.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

E. Utilization Management

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

ATC operates a comprehensive Utilization Management (UM) program that spans physical health, behavioral health, and pharmacy services. This program covers a broad spectrum of care settings, including preventive, emergency, primary, specialty, acute, short-term, long-term, and ancillary care services.

The UM program is integrated with the QI Program, which monitors data, evaluates clinical and consumer satisfaction, and initiates corrective actions when areas for improvement are identified. Relevant documents, such as the Provider Manual, Member Handbook, and various policies, outline the roles of the Pharmacy and Therapeutics Committee and the Preferred Drug List process. Express Scripts serves as the pharmacy benefit manager, and an up-to-date drug list is available for review on ATC's website.

The Utilization Management Committee (UMC) oversees all UM activities, including the approval of medical necessity criteria, policy review, and making recommendations. The UM Program undergoes an annual review and approval by both the UMC and the Quality Improvement Committee. Clinical oversight is provided by the Medical Director, with additional guidance from the Behavioral Health and Pharmacy Directors.

Coverage and Authorization of Services

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

The UM Program ensures that covered services are medically necessary, appropriate for the patient's condition, and delivered in the proper setting in accordance with professionally recognized standards of care. ATC has established criteria and procedures for evaluating medical necessity, and UM staff rely on these criteria when determining the necessity, level of care, and appropriateness of healthcare services.

ATC uses InterQual® guidelines for determining the medical necessity and appropriateness of physical health care services. For substance use disorder care, ATC uses the American Society of Addiction Medicine® (ASAM) criteria. These UM criteria, along with related policies, are reviewed and updated at least annually. Providers are informed of these criteria through orientation, the provider manual, and ATC's website. UM staff receive thorough training before making determinations and ongoing education as needed.

Inter-Rater reliability testing is conducted annually to ensure consistent application of clinical criteria. Results from the testing are reported in the UM Program Evaluation. Reviewers who score below 90% are provided with remediation or coaching to ensure uniformity in criteria application. In 2023, all domains met the 90% target, except for Behavioral Health Psychiatric and Durable Medical Equipment, which scored 85.7 %.

Medical necessity determinations are made by licensed professionals with appropriate clinical expertise in the relevant fields (medical, behavioral health, long-term services and supports).

These determinations consider services covered by ATC and are based on established medical benefit criteria.

Preauthorization is required for certain services, with providers or practitioners submitting formal requests to ATC prior to service delivery. Preauthorization is not necessary for emergency or urgent care services or for services restricted by state or federal guidelines.

All approval and denial files included documentation confirming timely communication of medical necessity determinations to relevant parties and clearly explaining the rationale behind the determinations. Letters sent to parties also provide details on the appeal process, including timeframes and instructions for State Fair Hearings.

Level I Reviews are conducted by clinical staff who have received training in the principles and procedures of utilization management and medical necessity reviews. A Level I review does not result in service denial, reduction, or termination based solely on medical necessity. Adverse benefit determinations can only be made by a Medical Director or a qualified designee during a Level II Review.

Level II reviews are conducted on a case-by-case basis by a Medical Director or a licensed clinical expert to assess the medical, behavioral health, and long-term service needs of the member. Final determinations from Level II reviews are made by Medical Directors or licensed individuals with relevant expertise.

The *SCDHHS Contract, Section 8.5.2.8* requires the health plans to develop a Preferred Provider Program that recognizes the provider's ability to manage care. For the 2023 EQR, Constellation found that ATC's Preferred Provider Program lacked details regarding the process for the identification, tracking, and notification to providers regarding the program. ATC responded with a Quality Improvement Plan (see *Attachment 4: Assessment of Quality Improvement Plans from Previous EQR*) and indicated revisions would be made to the policy (SC.UM.54, Preferred Provider Designation), provider notifications would be sent, the provider billing manual would be updated, and providers would be educated regarding the program during new provider orientation, at meetings, and a new flyer would be created. For this EQR, Constellation noted Policy SC.UM.54, Preferred Provider Designation, was not revised as mentioned in ATC's Quality Improvement Plan response. Also, the process for tracking and notifying providers of the program was not implemented. The lack of information regarding the process, tracking, and notification was discussed during the onsite and Constellation requested that ATC provide additional information. ATC responded and stated, "ATC does not have supplemental documents to provide for the Preferred Provider Program."

Appeals

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

Policy SC.MM.13, Member Appeals, the Member Handbook, the Provider Manual, and ATC's website describe processes for filing an appeal. Appeals are appropriately defined as a request to review

an "adverse benefit determination," and may be filed by a member, their authorized representative, or a provider filing on behalf of the member. Appeals are analyzed for trends which are reported to the Utilization Management Committee as reflected in quarterly committee materials.

Constellation reviewed a sample of appeal files and found all were resolved timely. One letter of acknowledgement was not sent within the five-calendar day timeframe as required by ATC's policy. It was found that one appeal was canceled due to lack of timely member eligibility verification. ATC should consider revising their process and reeducating staff regarding member eligibility verification. Investigation notes and communication to members and providers were detailed, with appropriately credentialed reviewers clearly indicated.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

ATC's care management program offers care coordination, transitional care, disease management programs, and specialized care management services for its members.

Members are referred to care management services through various referral resources. Once referred, outreach is initiated to conduct the initial assessment. After the assessment, members are stratified according to their assessed risk level. Policy CC.CM.02, Care Coordination CM Services, describes three levels of care for member stratification, which was inconsistent with the four levels of stratification described in the 2024 Absolute Total Care Medicaid Care Management Program Description. The health plan acknowledged that they are in the process of updating the policy to reflect the correct risk level assignment process for members.

The program follows an integrated care management model, where members are assigned a dedicated point of contact based on their identified medical or behavioral needs. The primary Care Manager is supported by a multidisciplinary Care Team that provides support for the members.

Care management performance is assessed through quality audits, monitoring of readmission rates, evaluating member satisfaction, etc. Upon reviewing the 2023 Case Management Program Evaluation, it was noted that the questions provided to members were not consistent with those outlined in Policy CC.CM.08, Attachment-CM Satisfaction Survey. ATC confirmed that the questions within the Program Evaluation were correct.

Constellation's review of the sample care management files indicated that care management activities were conducted as required, including conducting care management assessments, treatment planning, and linkage to appropriate community resources. However, there were three files that did not follow the unable to contact guidelines as outlined in Policy SC.PHCO.CM.01, Care Coordination.

Figure 7 indicates ATC met 96% of the standards in the UM section for this EQR. The Partially Met score was related to the documentation in the care management files and the Not Met score was related to the Preferred Provider Program.

Figure 7: Utilization Management Findings

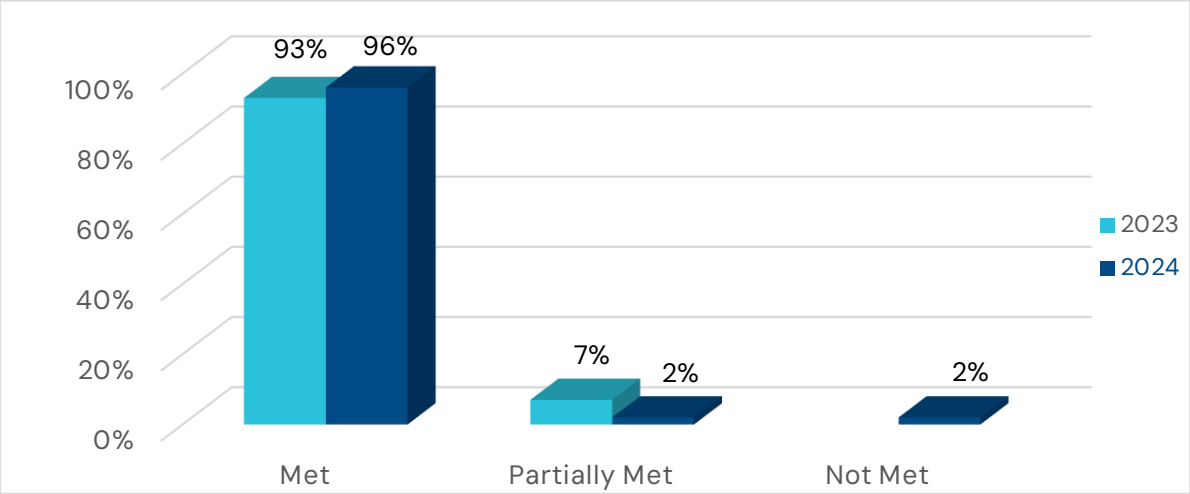


Table 26: Utilization Management Comparative Data

Section	Standard	2023 Review	2024 Review
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: The mechanism to provide for a preferred provider program	Partially Met	Not Met
Care Management and Coordination	Care management and coordination activities are conducted as required	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2023 to 2024.

Table 27: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
All denial files reviewed contained documentation that demonstrated timely communication to necessary parties as well as the basis for the denial determination.	✓		
All physical and behavioral health turnaround time metric goals were met/exceeded (urgent concurrent, non-urgent pre-service, urgent pre-service, and post-service reviews).		✓	
ATC launched a Foster Care Program in 2023 to address service needs gaps for members receiving foster care.	✓		
HALO (Health Assistance, Linkage and Outreach) is a holistic program tailored for members with substance use disorders designed to increase member engagement and create specialized services and personalized interventions for members.	✓		✓
For the 2024 EQR appeal file sample, all were resolved timely.		✓	

Table 28: Utilization Management Weaknesses

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
ATC's Preferred Provider Program lacked details regarding the process for the identification, tracking, and notification to providers regarding the program. This was a deficiency noted during the 2023 EQR and not corrected.	*Quality Improvement Plan: Develop a program description that clearly describes ATC's Preferred Provider Program. Include the process for identifying/selecting providers, provider notification, tracking or monitoring for the program, and staff and provider education conducted regarding the program. Also, include letter templates, flyers, logs, and monitoring reports related to the program.*	✓		
One appeal was inappropriately canceled due to member eligibility.	*Recommendation: Review and revise processes and training to address the timing of member eligibility verification specific to an appeal review.*			✓
Policy CC.CM.02, Care Coordination CM Services, describes three levels of care for member stratification, which is not consistent with the four levels described in the Care Management Program Description.	*Recommendation: Ensure that policies are updated to reflect the correct risk stratification levels for members.*	✓		
In review of the 2023 Case Management Program Evaluation, it was noted that the questions provided to members were not	*Recommendation: Update Policy CC.CM.08 Attachment-CM Satisfaction Survey to accurately*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
consistent with those outlined in Policy CC.CM.08, Attachment-CM Satisfaction Survey.	*reflect the care management satisfaction questions provided to members.*			
Three case management files did not follow the unable to contact guidelines as outlined Policy SC.PHCO.CM.01, Care Coordination and Case Management Program Description.	*Quality Improvement Plan: Reeducate staff on the unable to reach process and ensure adherence to the established policy standards.*	✓		

V. UTILIZATION MANAGEMENT

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V. A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					ATC has various policies and procedures that specifically address components of the UM process including the clinical decision criteria and application for UM decisions, timeliness, and communication standards, as well as the methods to ensure qualified licensed health professionals assess the clinical information used to support all UM decisions, including UM denials and appeals.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					Policy CC.UM.02, Clinical Decision Criteria and Application, outlines ATC's policy is to ensure clinical decisions made utilize all relevant clinical information and are based on objective and evidence-based criteria considering individual circumstances and local delivery systems.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					ATC's Program Description explains that UM criteria and the policies for application are reviewed at least annually and updated as appropriate. UM criteria are utilized as an objective screening guide and are not intended to be a substitute for physician judgment. 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

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						time of the request in addition to the local delivery system available for care.
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Policy CC. UM.05, Timeliness of UM Decisions–Notice, and Notifications, outlines the provisions related to standard prior authorizations and expedited/urgent requests.
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					ATC's UM employee compensation includes hourly and salaried positions. All medical management staff are required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.
1.7 the mechanism to provide for a preferred provider program.			X			The *SCDHHS Contract, Section 8.5.2.8* requires the health plans to develop a Preferred Provider Program that recognizes the provider's ability to manage care. For the 2023 EQR, Constellation found ATC's Preferred Provider Program lacked details regarding the process for the identification, tracking, and notification to providers regarding the program. ATC responded with a Quality Improvement Plan and indicated revisions would be made to the policy (Policy SC.UM.54, Preferred Provider Designation), provider notifications would be sent, the provider billing manual would be updated, and providers would be educated regarding the program during new provider orientation, at meetings, and a new flyer would be created. For this EQR, Constellation noted Policy SC.UM.54, Preferred Provider Designation, was not revised as

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						mentioned in ATC's QIP. Also, the process for tracking and notifying providers of the program was not implemented. The lack of information regarding the process, tracking, and notification was discussed during the onsite and Constellation requested ATC provide additional information. ATC responded and stated, "ATC does not have supplemental documents to provide for the Preferred Provider Program." *Quality Improvement Plan: Develop a program description that clearly describes ATC's Preferred Provider Program. Include the process for identifying/selecting providers, provider notification, tracking or monitoring for the program, and staff and provider education conducted regarding the program. Also, include letter templates, flyers, logs, and monitoring reports related to the program.*
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					ATC's Chief Medical Director, who has an unrestricted SC license, has operational responsibility for and provides support to the UM Program.
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 is evaluated at least annually and modifications to the program are made, as necessary. The Chief Medical Director, Vice President of Population Health and Clinical Operations or designee, and UM leadership evaluate the impact of the UM Program by using results of satisfaction surveys, member complaint, grievance and appeal data, and additional information as appropriate.
V. B. Medical Necessity Determinations *42 CFR § 438.210(a–e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					An overview of the InterQual® Level of Care and ASAM criteria sets utilized by the Plan for decision making are presented to the UM Committee on an annual basis for approval. The overview includes discussion of the key changes to the criteria as well as the process of considering severity of illness, comorbidities and complications, and the intensity of services being delivered.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					ATC covers hysterectomies and sterilizations pursuant to all applicable Federal and State laws and regulations, as detailed in Policy SC.UM.33, Abortions, and Policy SC.UM.45, Sterilization and Hysterectomies.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Policy CC.UM.32, Interrater Reliability – Staff, Medical Directors, and Therapists, promotes appropriate and consistent application of clinical criteria in decision making that is based on medical criteria, expert clinical opinion, and supported through a process of inter-rater reliability (IRR) testing.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					Policy CC.PHARM.09, Pharmacy Program, documents the prior authorization (PA) review process for Medicaid PA reviews, wherein Pharmacy Services reviews requests for medications designated as "PA required" on the plan's Preferred Drug List.
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					Emergency and post-stabilization services are defined in Policy SC.UM.12., Emergency Services, and are consistent with the contract and Federal regulations.
8. Utilization management standards/criteria are available to providers.	X					Providers are informed of UM criteria used to make benefit determinations. Providers are also informed of the opportunity to discuss any medical UM denial decision with a physician or other appropriate reviewer.
9. Utilization management decisions are made by appropriately trained reviewers.	X					Policy CC.UM.04, Appropriate UM Professionals, ensures qualified licensed health professionals assess the clinical information used to support all UM decisions, including UM denials and appeals. Appropriately licensed, qualified health professionals supervise the utilization management process and all medical necessity decisions.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					All approval files that were reviewed demonstrated prompt communication to the necessary parties.
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					All denial files reviewed contained evidence of attempts to obtain additional information when necessary and enough time was allowed for information to be received prior to making a benefit determination decision.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					All denial files that were reviewed contained evidence that an appropriate physician specialist reviewed the information prior to the denial.
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					All denial files reviewed contained documentation that demonstrated timely communication to necessary parties as well as the basis for the denial determination. Letters sent to necessary parties contained information on how to appeal a decision, the timeframes for filing an appeal, and information on State Fair Hearings.
V. C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:	X					Policy SC.MM.13, Member Appeals, the Member Handbook, and ATC's website describe processes for resolving requests by members or an authorized representative to reconsider an adverse benefit determination.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The term "appeal" is consistently defined as "A request for review of an action, as adverse benefit determination."
1.2 The procedure for filing an appeal;	X					Processes for filing a verbal or written appeal are clearly outlined in policy and member and provider materials.
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					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Policy, SC.MM.13, Member Appeals, the Member Handbook, Provider Manual, and the website provide appropriate timeframes for appeal filing, acknowledgment, extensions if needed, and resolution. Appeals are acknowledged within 5 calendar days from the date of receipt, with a 30-day timeframe for resolution, and a possible 14-day extension if needed.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.	X					Constellation reviewed a sample of appeal files and found all were resolved timely. The letter of acknowledgement was not sent within the five-calendar day timeframe as required by ATC's policy. It was found that one appeal was inappropriately canceled due to member eligibility. ATC should consider revising their process and reeducating staff regarding member eligibility verification. Investigation notes and communication to members and providers were detailed, with appropriately credentialed reviewers clearly indicated. *Recommendation: Review and revise processes and training to address the timing of member eligibility confirmation specific to an appeal review.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality	X					

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
improvement opportunities, and reported to the Quality Improvement Committee.						
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					ATC's care management program offers care coordination, transitional care, disease management programs, and specialized care management services as outlined in Policy SC.PHCO.CM.01, Care Management Program Description, Policy SC.PHC.CM.02, Foster Care Program Description, Policy SC.UM.41, Transition of Care, and Policy CC.DM.01, Population Health Management Operations Program Description.
2. The MCO has processes to identify members who may benefit from care management.	X					Members are referred for care management services through various resources such as community referrals, claims data, hospital staff, provider referrals, practitioner referrals, self-referrals, etc. Specialized population members within the foster care system, direct referrals from SC Department of Social Services caseworkers, etc. are considered high priority referrals as outlined in Policy SC.PHCO.CO.CM.01, Program Description, Policy CC.CM.02, Care management Services, Policy SC.PHCO.CM.02, Foster Care Program Description, and Policy CC.CM.06, Predictive Modeling Methodology.
3. The MCO provides care management activities based on the member's risk stratification.	X					As described in various policies, when a member is referred for care management services, outreach is initiated to conduct an initial assessment. After the

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						assessment, members are stratified according to their assessed risk level and categorized into four groups: low risk, moderate risk, high risk, and intensive case management, as outlined in Policy SC.PHCO.CM.01, Care Management Program Description. However, Policy CC.CM.02, Care Coordination CM Services, describes three levels of care for member stratification, which is not consistent with Policy SC.PHCO.CM.01, Care Management Program Description. The health plan acknowledged this inconsistency and described recent state regulatory changes to take effect 1/2/25 to explain the discrepancy. The health plan stated that they are currently in the process of updating the policy to reflect the correct four level risk level assignment. Additionally, ATC offers specialized programs to meet the unique needs of members. These include Choose Tomorrow, focused on suicide prevention; HALO (Health Assistance, Linkage and Outreach), which supports individuals with substance use disorders; and a newly launched Foster Care program, designed to bridge the gap in care for members in foster care. *Recommendation: Ensure that policies are updated to reflect the correct risk stratification levels for members.*
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					ATC's Care Management Program is built on evidence-based guidelines and adheres to the Case Management Society of America Standards of Practice for Case Management. The program follows an integrated care management model, where

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						members are assigned a dedicated point of contact, a primary Care Manager, based on their identified medical or behavioral needs. The primary Care Manager is supported by a multidisciplinary Care Team as needed, which may include Medical Directors, licensed Social Workers, other medical or behavioral health professionals, Program Coordinators, Member Connections Representatives, and Community Health Services Representatives to provide support to the members. Targeted Care Management services are provided for members with specialized needs, such as children in foster care, children in the juvenile system, and chronically mentally ill adults. Additionally, condition-specific programs are available for members, including autism case management, cancer care, the Emergency Department Diversion Program, and Hepatitis C management, etc.
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					
6. Care Transitions activities include all contractually required components.						
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					As described in the Member Handbook and various policies, ATC has licensed care coordination staff to assist with transitional care services. The transition of care service is provided for members to ensure a continuation of services while the member is in the appeals process, pregnant at the time of enrollment, disenrollment, and inpatient at the time of enrollment.

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					As outlined in various policies, care management performance is assessed through quality audits, monitoring readmission rates, evaluating member satisfaction, etc. Upon reviewing the 2023 SC Medicaid Care Management (CM) Program Evaluation, it was noted that the questions provided to members were not consistent with those outlined in Policy CC.CM.08, Attachment-CM Satisfaction Survey. During the onsite discussion, ATC acknowledged the inconsistencies with the questions within the policy and CM Program Evaluation; however, ATC confirmed that the questions within the CM Program Evaluation were correct. *Recommendation: Update Policy CC.CM.08 Attachment-CM Satisfaction Survey to accurately reflect the care management satisfaction questions provided to members.*
8. Care management and coordination activities are conducted as required.		X				Constellation's review of the sample care management files indicated that care management activities were conducted as required, including conducting care management assessments, treatment planning, and linkage to appropriate community resources. However, three sample CM files reviewed reflected that staff did not follow the unable to contact guidelines as outlined Policy SC.PHCO.CM.01, Care Coordination and Case Management Program Description. Specifically, two cases were closed

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						before the required three contact attempts, and one was closed without a follow-up letter being mailed to the member. *Quality Improvement Plan: Reeducate staff on the unable to reach process and ensure adherence to the established policy standards.*
V. E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

F. Delegation

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

The delegation review includes health plan policies and processes for delegating activities to external entities and conducting appropriate oversight of approved delegates. For this review, ATC reported 23 delegation agreements as shown in *Table 29: Delegated Entities and Services*.

Table 29: Delegated Entities and Services

Delegated Entities	Delegated Services
• Centene Pharmacy Services	Pharmacy - Claims, Credentialing, Network Management
• Centene Vision	Claims/Payments, Provider Payment Appeals, Credentialing - Practitioners Utilization Management
• Evolent - National Imaging Associates (NIA)	Customer Service Utilization Management, Utilization Management - Member Appeals
• Evolent - New Century Health (NCH)	Utilization Management
• Express Scripts, Inc. (ESI)	Care Management - Medication Therapy Management, Pharmacy Services - Claims, Credentialing, Network Management
• Focus Behavioral Health	Utilization Management - Peer Review Services Behavioral Health
• Medical Review Institute of America, Inc	Utilization Management, Utilization Management - Member Appeals
• AnMed Health • AU Medical Center • Bon Secours Ambulatory Services • CVS Health Minute Clinic • Health Network Solutions • LCH Group Inc. and Subsidiaries • Lexington County Health Services District • Medical University of South Carolina • Novant Choice Health • Preferred Care of Aiken • Prisma Palmetto USC • Regional Health Plus Spartanburg • Roper St. Francis Physicians Network • Self Regional Health Care • St. Frances Physician Services • United Physician	Credentialing and Recredentialing

Policy CC.QI.14, Oversight of Delegated Activities, outlines ATC's policy and procedure for the oversight of delegated activities. ATC evaluates the delegate's capacity by conducting a pre-delegation evaluation before entering into a delegation agreement with the delegate. This evaluation includes a review of the entity's structure, policies, staffing, and performance, with a site visit preferred. ATC conducts an annual evaluation of the delegate's programs and performance, with a summary presented to the appropriate committee. Section 1.5 of the Delegated Agreement outlines the conditions under which the delegate may subdelegate its responsibilities to another entity including the requirement for prior approval from the Health Plan.

For this review ATC provided a list of delegates with the desk materials, along with sample contracts and monitoring documentation. During the desk review it was noted that none of the annual audit results were received. Constellation reached out and requested additional information. ATC indicated the list of vendors submitted with the desk materials was inaccurate and a corrected list was provided.

For this EQR, ATC reported delegation agreements with 23 subcontractors. The delegated services include pharmacy services, utilization management, care management, vision services, and credentialing. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

Last year (2023), ATC was not reporting the Delegation Oversight Report to the Credentialing Committee. ATC provided a Quality Improvement Plan for this issue. During the current EQR, Constellation found the QIP had been implemented, and the delegation oversight reports were presented to the Credentialing Committee. For the 2024 EQR, Constellation found ATC met all the requirements in the Delegation Section as noted in the Figure that follows:

Figure 8: Delegation Findings

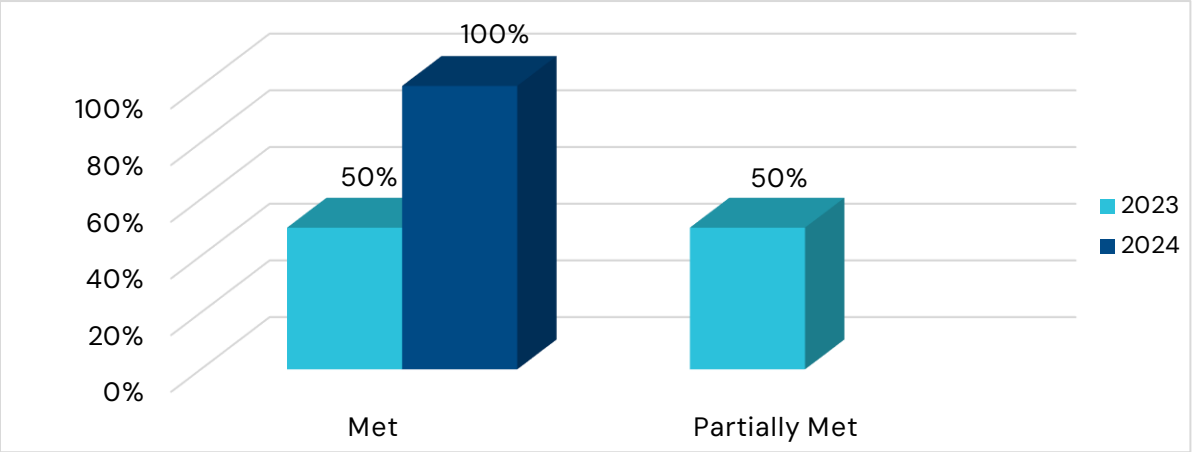


Table 30: Delegation Comparative Data

Section	Standard	2023 Review	2024 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 2023 to 2024.

Strengths for the Delegation section are included in the following table.

Table 31: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
The Delegation Oversight Program includes pre-delegation assessments, ongoing monitoring, and comprehensive annual audits. This ensures that third-party entities consistently meet performance and compliance standards, providing a robust framework for accountability.	✓		
ATC requires that all third-party entities enter into detailed written agreements specifying delegated activities, reporting responsibilities, compliance with laws and regulations, and audit rights.	✓		

VI. DELEGATION

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has established processes for delegation of health plan activities to subcontractors, and the processes meet contractual requirements.	X					Policy CC.QI.14, Oversight of Delegated Activities, outlines ATC's policy and procedure for the oversight of delegated activities. ATC evaluates the delegate's capacity before entering into a delegation agreement by conducting a pre-delegation evaluation. This evaluation includes a review of the entity's structure, policies, staffing, and performance, with a site visit preferred. ATC conducts an annual evaluation of the delegate's programs and performance, with a summary presented to the appropriate committee. Section 1.5 of the Delegated Agreement outlines the conditions under which the delegate may subdelegate its responsibilities to another entity including the requirement for prior approval from the Health Plan.
2. 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					
3. 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					For this review ATC provided a list of delegates with the desk materials, along with sample contracts and monitoring documentation. During the desk review it was noted that none of the annual audit results were received. Constellation reached out and requested additional information. ATC indicated the list of

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						vendors submitted with the desk materials was inaccurate and a corrected list was provided. For this EQR, ATC reported delegation agreements with 23 subcontractors. The delegated services include pharmacy services, utilization management, care management, vision services, and credentialing. Copies of the annual delegation audits and monitoring reports were provided for all delegates.

G. Mental Health Parity

The Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008 requires health plans who provide mental health (MH), and substance use disorder (SUD) benefits to structure their benefit package to reflect no more restrictions and limitations on MH and SUD benefits than are present for medical/surgical (M/S) benefits. Constellation completed a Mental Health Parity Assessment as part of the annual EQR. The following sections outline the results of ATC's 2024 Mental Health Parity review, which examined both quantitative and non-quantitative benefit limitations. Quantitative treatment limitations (QTLs) are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. Non-quantitative treatment limitations (NQTLs) are differences in standards applied, either in comparability or in the stringency with which the adopted standards are applied between MH, SUD, and M/S service requests.

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

ATC provided descriptions for Quality and the Utilization Management programs, information on appeals and denials, network access, out of network utilization, and an analysis of NQTL comparison with benefit administration.

ATC's policies and procedures continue to support Mental Health Parity, both in comparability and stringency. Constellation inquired about a Behavioral Health Program Description (referenced on page 37 of the Quality Improvement Program Description), and were told this material is covered in the general UM Program Description. Clarifying there is only one UM Program Description covering MH/SUD and M/S would be beneficial going forward. InterQual and ASAM continue to be the evidence-based criteria used to review service requests requiring clinical review. Denial and appeal rates do not reveal areas of concern in either comparability or stringency.

Inter-Rater Reliability testing of reviewers demonstrated the need for additional training in the BH Psychiatric and Durable Medical Equipment subsets. This reinforcement was provided and scores for both went up for both review areas showing appropriate identification of areas for clarification and effective remediation. Constellation notes that UM Reviewers are referred to as "nurses" which does not reflect the presence of the licensed behavioral health staff that review MH cases.

ATC meets the requirements of the Mental Health Parity Act, both through their written policies and procedures, and through the effective implementation, assessment, and support required to meet the needs of the population they are trusted to serve.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to ATC to complete the mental health parity assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information is then used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. There were no financial requirements or day/session limits noted for pharmacy, emergency, inpatient, nor outpatient for medical/surgical nor for mental health categories. Thus, parity is met.

Table 32: Mental Health Parity Quantitative Treatment Limitations Assessment Steps provides an overview of the results.

Table 32: Mental Health Parity Quantitative Treatment Limitations Assessment Steps

Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment
Inpatient	N/A	N/A	Accepted
Outpatient	N/A	N/A	Accepted
Pharmacy	N/A	N/A	Accepted
Emergency Services	N/A	N/A	Accepted

Note. N/A – As directed by SCDHHS, effective 7/1/2024, there will be no copays for service classification based on a memo sent to the managed care plan on May 6, 2024.

Overall, ATC met the requirements of the Mental Health Parity Act as noted in *Figure 9: Mental Health Parity Findings*.

Figure 9: Mental Health Parity Findings

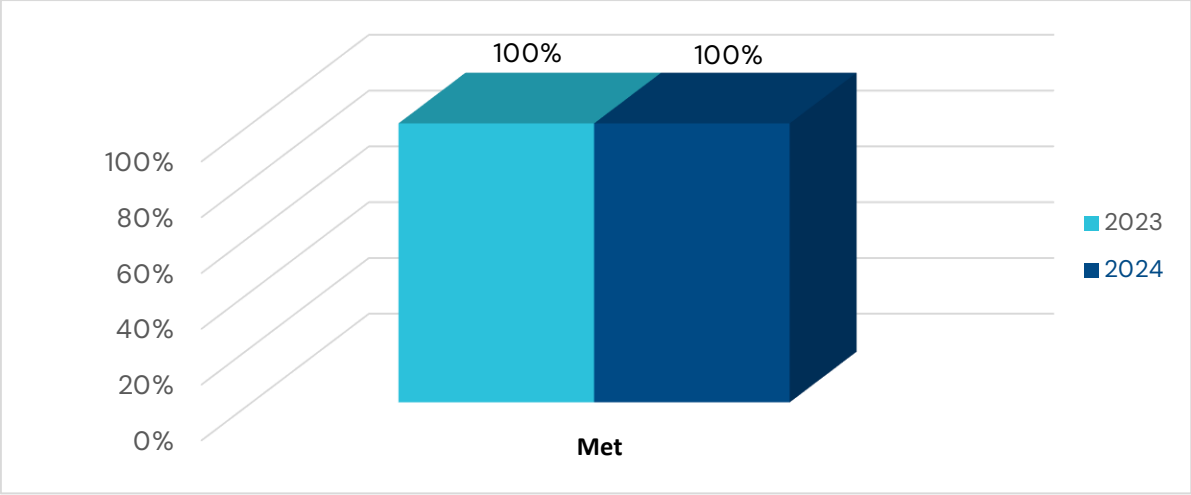


Table 33: Mental Health Parity Strengths

Strengths	Quality	Timeliness	Access to Care
There is 100% Geo Access for psychiatrists, psychologists, and licensed therapists.			✓
Stringency with which UM criteria is applied is comparable.			✓
Procedure changes were implemented that will improve access to care, particularly for behavioral health.			✓
Policies and standards are equivalent.	✓		
BH licensed staff are well represented in utilization management.	✓		✓

Table 34: Mental Health Parity Weakness

Weakness	Recommendation	Quality	Timeliness	Access to Care
A higher rate of out of network authorization requests for MH/SUD was noted compared to medical/surgical.	*Recommendation: Separate data for MH from SUD to help determine root cause.*			✓

Weakness	Recommendation	Quality	Timeliness	Access to Care
Lower level of satisfaction getting MH/SUD appointments both routine and urgent care than M/S population.	*Recommendation: Separating MH and SUD data could also help pinpoint specifically which subset of this population is having the issue of accessing care.*			✓

VII. MENTAL HEALTH PARITY

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. MENTAL HEATLH PARITY						
1. The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations.	X					A higher rate of out-of-network authorization requests for MH/SUD was noted compared to medical/surgical. *Recommendation: Separate data for MH from SUD to help determine root cause.* Lower level of satisfaction getting MH/SUD appointments both routine and urgent care than M/S population. *Recommendation: Separating MH and SUD data could also help pinpoint specifically which subset of this population is having the issue of accessing care.*
2. The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	X					

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets
- Attachment 4: Assessment of Quality Improvement Plans from Previous EQR

Attachment 1: Initial Notice and Materials Requested for Desk Review

October 7, 2024

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 2024 External Quality Review (EQR) of Absolute Total Care is being initiated. An external quality review (EQR) conducted by Constellation Quality Health (Constellation) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by Constellation 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, a virtual onsite visit and will address all contractually required services as well as follow-up of any areas of weakness identified during the previous review. The Constellation EQR team plans to conduct the virtual onsite on December 11th and December 12th. In preparation for the desk review, the items on the enclosed desk materials list should be provided to Constellation no later than October 21, 2024.

To help with submission of the desk materials, we have set up a secure file transfer site to allow health plans under review to submit desk materials directly to Constellation through the site. The file transfer site can be found at: https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Project Manager, External Quality Review

cc: SCDHHS

External Quality Review 2024

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base. Please include all of the following:
    . A list of all contracted status 1 and status 2 Providers. This list should be submitted as an excel spreadsheet and include county, specialty, provider identified limitations (open or closed panel), and a description for any codes used in the spreadsheet.
    a. Geographic access assessments
    b. Network development plans
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios (PCP and specialist)
    f. Analysis of in-network and out-of-network utilization data

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

Excel Spreadsheet Format

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

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

7. A completed Provider Network File Questionnaire.

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

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

10. A copy of the Credentialing, Quality Improvement, Medical/Utilization Management, Disease/Case Management, Population Health Management, and Pharmacy Program Descriptions.

11. The Quality Improvement work plans for 2023 and 2024.

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

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

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

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

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

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

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

19. A complete list of all members enrolled in the case management program from October 2023 through September 2024. Please include open and closed case management files, the member's name, Medicaid ID number, and condition or diagnosis which triggered the need for case management.

20. Copies of new employee training materials, annual staff training materials, other refresher training materials, and training logs for October 2023 through September 2024. Ensure this includes any training related to appeals and grievances. Also provide copies of the employee handbook and any scripts used by Member Services Representatives and Call Center personnel.

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of October 2023 through September 2024.

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

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

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

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

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

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

30. A copy of the provider handbook or manual.

31. A sample provider contract.

32. Documentation supporting requirements included in the Information Systems Capabilities Assessment for Managed Care Organizations (ISCAs). Please provide the following:
    a. 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 policies with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

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

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

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

35. Results of the most recent annual evaluation and ongoing monitoring activities for all delegated entities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.
36. All HEDIS data and other performance and quality measures collected or planned. Required data and information include the following:

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

37. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of October 2023 through September 2024. Include any medical information and physician review documentation used in making the denial determination.
    d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of October 2023 through September 2024, including any medical

information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

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

These materials:

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

Attachment 2: Materials Requested for Onsite Review

Absolute Total Care

External Quality Review 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

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

Attachment 3: EQR Validation Worksheets

EQR PIP Validation Worksheet

Plan Name:	Absolute Total Care
Name of PIP:	Adult Access to Preventive Health Care (AAP)
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	Topic was selected based on research and analysis of data.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	The measure was clearly defined in the PIP report.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure processes of care.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	Systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to HEDIS specifications
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel that are involved in the data collection and their qualifications are mentioned.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements are documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NOT MET	A decline in the annual rate from 2021 (78.18%) to 2022 (72.46%). The My 2023 rate in the quarterly quality assessment document showed a rate of 76.73%. *Recommendation: Continue efforts to educate members on the importance of attending preventive care appointments using outreach and at events.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	The indicator did not show improvement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	No improvement to examine statistical significance.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

Step	Possible Score	Score
Step 1		
1.1	5	5
Step 2		
2.1	10	10
Step 3		
3.1	1	1
3.2	1	1
Step 4		
4.1	NA	NA
4.2	NA	NA
4.3	NA	NA
Step 5		
5.1	10	10
5.2	1	1
Step 6		
6.1	5	5
6.2	1	1
6.3	1	1
6.4	5	5
6.5	1	1
6.6	5	5
Step 7		
7.1	5	5
7.2	10	10
7.3	1	1
7.4	1	1
Step 8		
8.1	10	10
Step 9		
9.1	1	0
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	73
Project Possible Score	74
Project Rating Score	99%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Absolute Total Care
Name of PIP:	Hospital Readmissions
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	The topic was selected based on research and analysis of data.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	NA	Sampling was not used.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	NA	Sampling was not used.
4.3 Did the sample contain a sufficient number of enrollees? (5)	NA	Sampling was not used.
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	The measure was clearly defined in the PIP report.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure processes of care and health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	A systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to appropriate specifications.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel that are involved in the data collection and their qualifications are mentioned.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements are documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The baseline rate for the number of hospital readmissions that occur within 30 days of an inpatient discharge declined from 15.5% in 2022 to 15.3% in 2023. The benchmark is set at 15%. A reduction indicates improvement.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	The indicator did not show improvement.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Ch-square test was conducted to assess significance.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	PIP retired as of Jan 1, 2024.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	80
Project Possible Score	80
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR PIP Validation Worksheet

Plan Name:	Absolute Total Care
Name of PIP:	Timeliness of Prenatal Care
Reporting Year:	2023
Review Performed:	2024

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 1: Review the Selected Study Topic(s)		
1.1 Was the topic selected through data collection and analysis of comprehensive aspects of enrollee needs, care, and services? (5)	MET	The topic was selected based on research and analysis of data. The South Carolina Department of Health and Environmental Control (SCDHEC) reports that South Carolina has seen a dramatic increase in both maternal and infant mortality rates.
Step 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? (10)	MET	Study aim was found in the project documentation.
Step 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? (1)	MET	A broad spectrum of enrollee care and services are addressed.
3.2 Does the PIP document relevant populations (i.e., did not exclude certain enrollees such as those with special health care needs)? (1)	MET	All relevant populations are included.
Step 4: Review Sampling Methods		
4.1 Did the sampling technique consider and specify the true (or estimated) frequency of occurrence of the event, the confidence interval to be used, and the margin of error that will be acceptable? (5)	MET	HEDIS specifications were utilized.
4.2 Did the plan employ valid sampling techniques that protected against bias? (10) *Specify the type of sampling or census used:*	MET	Sampling technique allows for minimization of biases.
4.3 Did the sample contain a sufficient number of enrollees? (5)	MET	Sample was 411, which is per HEDIS specifications.

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
Step 5: Review Selected PIP Variables and Performance Measures		
5.1 Did the study use objective, clearly defined, measurable indicators? (10)	MET	The measure was clearly defined in the PIP report.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? (1)	MET	Indicators measure processes of care and health status.
Step 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? (5)	MET	Study design clearly specifies data collection cycle.
6.2 Did the study design clearly specify the sources of data? (1)	MET	Study design describes the sources of the data.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? (1)	MET	A systematic method of collecting data is being used.
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? (5)	MET	Data collection was conducted according to appropriate specifications.
6.5 Did the study design prospectively specify a data analysis plan? (1)	MET	Data analysis plan was provided
6.6 Were qualified staff and personnel used to collect the data? (5)	MET	The personnel that are involved in the data collection and their qualifications are mentioned.
Step 7: Review Data Analysis and Interpretation of Study Results		
7.1 Was an analysis of the findings performed according to the data analysis plan? (5)	MET	Analysis was conducted according to plan.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? (10)	MET	Results were presented clearly in table and chart format.
7.3 Did the analysis identify: initial and repeat measurements, statistical significance, factors that influence comparability of initial and repeat measurements, and factors that threaten internal and external validity? (1)	MET	Baseline and repeat measurements are documented.
7.4 Did the analysis of study data include an interpretation of the extent to which its PIP was successful and what follow-up activities were planned as a result? (1)	MET	Project documentation included both qualitative and quantitative discussion of results.
Step 8: Assess Improvement Strategies		

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	NA	Baseline rate only.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	NA	Baseline rate only.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	NA	Baseline rate only.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Too early to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

Project Score	93
Project Possible Score	93
Project Rating Score	100%

Audit Designation
High Confidence in Reported Results

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

EQR Performance Measure Validation Worksheet

Plan Name:	Absolute Total Care
Name of PM:	All HEDIS® Measures
Reporting Year:	2024 (MY2023)
Review Performed:	2024

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2023 Volume 2 Technical Specifications

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

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D1 Denominator	Data sources used to calculate the denominator (e.g., claims files, medical records, provider files, pharmacy records) were complete and accurate.	MET	Denominator sources were accurate.

DENOMINATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
D2 Denominator	Calculation of the performance measure denominator adhered to all denominator specifications for the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of rates adhered to denominator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	MET	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	MET	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	MET	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	MET	Integration methods were found to be compliant.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N5 Numerator – Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	MET	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1 Reporting	Were the state specifications for reporting performance measures followed?	MET	HEDIS specifications were followed and found compliant.
Overall Assessment			Plan uses NCQA certified software. Attest Health Care Audit report noted compliance for HEDIS measures.

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

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

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

Audit Designation
Fully Compliant

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

EQR Network Adequacy Validation Worksheet

Plan Name:	Absolute Total Care
Reporting Year:	2023
Review Performed:	2024

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

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
Component / Standard (Total Points)	Score	Comments
2.1 Are the methods selected by the MCO appropriate for the state? (10)	MET	Methods aligned with State standards.
2.2 Are the methods selected by the MCO appropriate to the state Medicaid and CHIP population(s)? (10)	MET	Methods aligned with populations.
2.3 Are the methods selected by the MCO adequate to generate the data needed to calculate the indicators according to the State's expectations? (10)	MET	Methods generated required data for network adequacy assessment.

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

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

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

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

Points Earned	99
Possible Score	99
Validation Findings	100%

Audit Designation
High Confidence in Reported Results

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

EQR Survey Validation Worksheet

Plan Name	Absolute Total Care
Survey Validated	CAHPS MEMBER SATISFACTION – ADULT
Validation Period	2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023.
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023.
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	The survey audience is identified in the report. *Documentation:* Press Ganey Adult CAHPS Report MY2023.

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	The survey has been tested for validity. *Documentation:* Press Ganey Adult CAHPS Report MY2023
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Adult CAHPS Report MY2023

Survey Element		Element Met / Not Met	Comments and Documentation
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult CAHPS Report MY2023
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Adult CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Adult CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult CAHPS Report MY2023

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Adult CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult CAHPS Report MY2023

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Adult CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 11.9%, an improvement over the previous response rate of 11.5%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult CAHPS Report MY2023
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Adult CAHPS Report MY2023
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult CAHPS Report MY2023

EQR Survey Validation Worksheet

Plan Name	Absolute Total Care
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD
Validation Period	2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2023
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2023
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	The survey audience is identified in the report. *Documentation:* Press Ganey Child CAHPS Report MY2023

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	The survey has been tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2023
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	The survey has been tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	The study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2023

Survey Element		Element Met / Not Met	Comments and Documentation
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CAHPS Report MY2023
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Child CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child CAHPS Report MY2023

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CAHPS Report MY2023

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 9.3%, a decline from the previous rate of 10.0%. As well, the response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CAHPS Report MY2023
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CAHPS Report MY2023
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CAHPS Report MY2023

EQR Survey Validation Worksheet

Plan Name	Absolute Total Care
Survey Validated	CAHPS MEMBER SATISFACTION – CHILD CCC
Validation Period	2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective is documented in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience is identified in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey has been tested for validity. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey has been tested for reliability. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates are in accordance with standards. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate is reported and bias in generalizability is documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan is documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023.
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The response rate was 8.8%, a decline from the previous rate of 9.7%. Also, the response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

Results Elements		Validation Comments and Conclusions
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CCC CAHPS Report MY2023

Attachment 4: Assessment of Quality Improvement Plans from Previous EQR

Absolute Total Care 2023 EQR Quality Improvement Plan Response and Review

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
ADMINISTRATION			
I D. Compliance/Program Integrity			
2. The Compliance Plan and/or policies and procedures address requirements, including: 2.11 Exclusion status monitoring.			
Policy CC.COMP.36, Centene Exclusion Screening Requirements, states Federal and State exclusion screening standards apply to Beneficial Owners, the Board of Directors, employees, contingent workers, and vendors at the time of affiliation or employment. Thereafter, monthly screening of federal and state databases is conducted to determine exclusion status. The policy provides detailed information about the process followed if an individual or entity is found to be possibly ineligible. The policy lists the queried databases as, at minimum: • Office of Inspector General's List of Excluded Individuals/Entities (OIG LEIE) • General Services Administration's System for Award Management (SAM) • State exclusion lists for states in which Centene operates Policy CC.COMP.36 does not address querying the Social Security Death Master File (SSDMF) for subcontractors and persons with ownership or control interest or who are agents or managing employees of the MCO. This requirement is noted in the *SCDHHS Contract, Section 11.2.10*. During onsite discussion, the process for conducting queries of the SSDMF was discussed. ATC staff verbalized the process for querying the SSDMF for network providers at initial credentialing	<u>2/01/24 ATC Response</u> The CC.COMP.36 SC Addendum has been revised to include our process for conducting queries of the SSDMF and ensure they are conducted timely. During Centene's Human Resources onboarding process for all employees, the SSDMF is searched and there would not be a need to re-screen employees against the SSDMF. In researching all relevant information regarding this QIP we have discovered conflicting instructions between the SC contract and P&P Section 11.2.10. We believe the language that we have been operating under is that in the P&P. During a previous clean-up of the contract, the reference to Subcontractor was inadvertently changed to Contractor. We would like to get clarification on this if possible. <u>The contract states:</u> 11.2.10. Process to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor, that is not a South Carolina Medicaid Network Provider as well as any person with an ownership or control interest, or who is an agent or managing employee of the CONTRACTOR through routine checks of federal databases. This includes the Social Security Administration's Death Master File, the List	✓	

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
and monthly thereafter. However, health plan staff were unable to verbalize the process for conducting SSDMF queries for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. *Quality Improvement Plan: Revise Policy CC.COMP.36, Centene Exclusion Screening Requirements, or develop a South Carolina-specific policy to define the process for conducting queries of the SSDMF for subcontractors and persons with ownership or control interest or who are agents or managing employee of the MCO. Ensure this process is implemented and conducted timely.*	of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the Department or Secretary of Health and Human Services may prescribe (e.g. Department's SC List of Excluded Providers or the SC List of Providers Terminated for Cause. The P&P says: Section 11.2.10 through 11.2.11.1: The MCO will establish written Policies and Procedures adopting routine checks of federal and state databases to confirm the identity and determine the exclusion status of any Provider and/or Subcontractor that is not a South Carolina Medicaid Network Provider, and any person with an ownership or control interest, or an agent, or managing employee of the Provider and/or Subcontractor. This includes checking the Social Security Administration's Death Master File, the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases the Department or the Secretary of Health and Human Services may prescribe (e.g., the South Carolina List of Excluded Providers or the South Carolina List of Providers Terminated for Cause). MCO written Procedures shall include requirements that the MCO shall check federal and state Provider exclusion and termination for cause databases upon contracting or Credentialing the Provider and no less than monthly thereafter. 2/23/24 ATC RESPONSE: ATC is waiting on clarification from SCDHHS to implement the process of SSDMF. 3/22/24 ATC response: The CC.COMP.36 SC Addendum has been revised to include our process for conducting queries of the SSDMF and ensure they are conducted timely.		
PROVIDER SERVICES			
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*			
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.			

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
The Centene Corporation Credentialing Program Description provides a brief overview of the Credentialing Program. Specific processes and requirements are detailed in Policy CC.CRED.01, Practitioner Credentialing and Recredentialing, and in Policy CC.CRED.09, Organizational Assessment and Reassessment. Additional policies address topics such as confidentiality in the credentialing process, nondiscrimination, site reviews, sanction monitoring, etc. Policy CC.CRED.01 indicates ATC will process practitioner credentialing applications within 60 calendar days of receipt of a complete application, including all necessary documentation and attachments. However, Policy CC.CRED.09 does not define the timeframe within which ATC will process credentialing applications for organizational providers. *Quality Improvement Plan: Revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers.*	2/01/24 – ATC Response: Credentialing will revise Policy CC.CRED.09 to include the timeframe for processing credentialing applications for organizational providers. 2/23/24 ATC RESPONSE: The timeframe for processing is found on page 53, number 26 of Policy CC.CRED.09.	✓	
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*			
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)* 2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.			
As noted in Policy CC.PRVR.19, Provider Directory – Portico, ATC maintains a searchable, printable, web-based Provider Directory that includes all network providers. The policy lists elements that must be included in the Provider Directory and details processes for maintaining provider information for the directory. Information submitted along with the desk materials for this review indicated that instead of sending members a printed provider directory, ATC sends a letter providing the member with a list of their active local providers and instructs them to call ATC or to use the find-a-provider tool on ATC's website to identify additional providers as needed.	2/01/24 ATC Response: The following statement will be added to the Medicaid Member Home page (https://www.absolutetotalcare.com/members/medicaid.html) under the Member Quick Links icons and before the moral and religious statement AND to the Find a Provider page (https://findaprovider.absolutetotalcare.com/location) before the moral and religious disclaimer. *PCP Choice: Multiple members of a family enrolled with Absolute Total Care may all choose the same PCP or each member may choose a different PCP.*	✓	

2023 EQR Findings	Actions Taken by the Health Plan to Address Findings	2024 EQR Findings	
		Corrected	Not Corrected
The *SCDHHS Contract, Section 3.12.5.10*, requires that the Provider Directory include "An explanation to all potential Members that an enrolled family may choose to have all family members served by the same PCP or may choose different PCPs based on each family member's needs." This explanation was not noted in the online Find a Provider tool. *Quality Improvement Plan: Add a statement to the online Find a Provider Tool that when multiple members of a family are enrolled with ATC, they may all choose the same PCP, or they may choose different PCPs for each family member.*	The following statement will be added to the Medicaid Member Handbook under the Choosing Your Primary Care Provider (PCP) heading. *Multiple members of a family enrolled with Absolute Total Care may all choose the same PCP or each member may choose a different PCP.* <u>2/23/24 ATC RESPONSE:</u> 1) Currently our public website is undergoing a migration from AEM to a new cloud version AEM environment to improve both accessibility and usability. The migration process began in the late 2023 and is scheduled to go-live February 27, 2024. Any tickets submitted and worked during the migration are not guaranteed to transfer. Once the migration is final on February 27, 2024 a ticket will been submitted to incorporate the requested language on the find the provider tool to ensure compliance is met. 2) We are currently making multiple updates to the Member Handbook to satisfy guidance released by SCDHHS on 1/1/24 and 2/1/24. To avoid multiple SCDHHS submissions, once all changes are completed, we will submit the Member Handbook to the State for review and approval. Please see current redline* version as evidence that the changes are being implemented to "*Choosing Your Primary Care Provider (PCP)*" heading. <u>3/4/24 ATC Response:</u> The Web migration was completed on 2/27/24 and ticket ID 2246 was submitted. The request has been added to the Minor Enhancements list and is pending a response regarding estimated time to complete. An updated was requested on the status this morning.		
UTILIZATION MANAGEMENT			
V A. The Utilization Management (UM) Program			
1.7 the mechanism to provide for a preferred provider program.			
Policy SC.UM.54, Preferred Provider Designation, provides an overview of their Preferred Provider process. However, during onsite discussion, ATC was unable to sufficiently describe the Preferred Provider Designation process. ATC stated	<u>2/01/24 ATC Response:</u> The process is outlined in SC.UM.05: 1. Any one member on the Utilization Management Committee (UMC) can nominate and propose to designate any Participating Provider (PAR) as		✓

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that once a provider obtains Preferred Provider status that it is communicated to the provider; however, ATC was unable to describe their process for identification and tracking preferred provider status. Also, ATC was not able to describe the health plan's process for making providers aware of the program. *Quality Improvement Plan: Develop and implement a Preferred Provider Program in accordance with the SCDHHS Contract, Section 8.5.2.8 and outlined in Policy SC.UM.54, Preferred Provider Designation, with a process for making providers aware of the program.*	a preferred provider, known as the "sponsor" would notify the secretary of the UMC prior to the quarterly UMC to add to the agenda. 2. During the UMC, the sponsor will present two things that are voted on separately. a. First, their nomination and justification why the provider should be designated as a preferred provider and if approved, will then; b. Propose what relaxed or exempt authorization benefits should be approved for this provider. 3. Once both are approved, a future effective date will be decided by Population Health and Clinical Operations (PHCO) and Provider Engagement (PE). PHCO will initiate and complete the necessary ARQ and claims configuration changes. 4. PE will initiate provider notification to include both written notification and scheduled meetings with the appropriate provider rep. 5. PHCO works with PE to incorporate the PPD P&P in the new provider orientation and quarterly town halls. Will also add a section to the provider billing manual and update accordingly with information on the PPD P&P and publish with the next update. Can also work with marketing to create a flyer that can be sent to providers and/or posted on our website <u>2/23/04 ATC RESPONSE:</u> 1) ATC Mistakenly noted SC.UM.05 in original response. 2) ATC is updating SC.UM.54 Preferred Provider Designation Policy to ensure contract compliance. 3) ATC's Multidisciplinary Leadership team will update and review all future versions. The Preferred Provider Designation policy will be added to the provider manual after updates to the policy. <u>3/24/24 ATC RESPONSE:</u> Submit the revised policy (SC.UM.54) referenced.		
11. Denials 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			

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Constellation Quality Health's review of a sample of denial decisions demonstrated that adverse benefit determinations were promptly communicated to the provider and member. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, in four sample denial files, the adverse benefit determination notices incorrectly informed the member that a written appeal is required within fourteen days of an oral request. This is no longer a contractual requirement. During onsite discussion, ATC reported they conducted a compliance audit in June 2023 and ensured that the verbiage was removed. *Quality Improvement Plan: Remove from adverse benefit determination notices that a written appeal request is required when an oral request is submitted.*	2/01/24 ATC Response: 1. A project was created to create and update the denial letter to have just one member denial letter that can be used for all adverse determinations. 2. ATC is deactivating all letters that are no longer authorized for use to prevent them from being used accidentally. By February 15, 2024. 2/23/24 ATC RESPONSE: The requested documentation has been uploaded for your review. The deactivation process involves submitting a ticket to the Centene business process team who is responsible for working and completing the ticket. All deactivated letters, once confirmed and approval to deactivate is obtained, require recoding and configuration so they can be archived that prevents a new letter from being generated while also still allowing the ability to access and view previously generated letters. The entire process averages 4 to 8 weeks, depending on certain expected and unexpected factors.	✓	
DELEGATION			
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*			
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.			
ATC provided documentation of oversight conducted for non-credentialing and credentialing delegates. For this EQR, ATC provided the annual evaluation for all entities and no issues were identified. However, Policy CC.CRED.12, Oversight of Delegated Credentialing, Section IV (Annual Evaluation, item E states, "Summary of the annual delegation review is recorded on the Report of Delegation Oversight Activities which is presented to the Credentialing and/or Quality Improvement Committee for review and approval." During the previous EQR, ATC reported that results of the annual oversight activities are reported to the health plan's QIC (for non-credentialing delegates) and to the Credentialing Committee (for	2/01/24 ATC Response: Credentialing will ensure that the Credentialing Committee Minutes reflect review of the credentialing delegation oversight. 2/23/24 ATC RESPONSE: At this time, we do not have the evidence to provide.	✓	

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credentialing delegates). However, minutes for 10 of 12 Credentialing Committee meetings did not reflect review and discussion of credentialing delegation oversight. A copy of the 2022 - 2023 SC Delegation Report was included in the folder with the Credentialing Committee minutes, however, it was not mentioned in any of the minutes reviewed. *Quality Improvement Plan: Ensure Credentialing Committee Minutes clearly and completely document review and discussion of credentialing delegation oversight activities.*			