CCME

2021 Readiness Review

HUMANA HEALTHLY HORIZONS

Submitted: May 7, 2021

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the Readiness Review that The Carolinas Center for Medical Excellence (CCME) conducted on behalf of the South Carolina Department of Health and Human Services (SCDHHS).

This review was to assess the preparedness of Humana Healthy Horizons (Humana) to enroll South Carolina Medicaid beneficiaries as members in their MCO and to provide the necessary and contractually required health care services to those members.

The objective of the review was to determine if Humana has the necessary administrative structure, staffing, policies and procedures, support services, provider availability, and member educational materials in place to: 1) commence enrollment, 2) deliver the contractually required services to members, and 3) prepare and submit contractually required reports to SCDHHS. The overriding goal of the Readiness Review process is to assure the contracted health care services can be delivered and will be of good quality.

The process CCME used for the Readiness Review is based on the protocols the Centers for Medicare & Medicaid Services (CMS) developed for Medicaid MCO External Quality Reviews (EQRs). The review includes a desk review of documents and a two-day virtual onsite visit.

Summary and Overall Findings

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

- 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 Humana's compliance with the quality, timeliness, and accessibility of services, CCME's review was divided into six areas. The following is a high-level summary of the review results for those areas.

Administration

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

The review of the Administration section covered the areas of policies, staffing levels, compliance information systems, and confidentiality. Many of the policies received in the desk materials contained wording directly from the *SCDHHS MCO Contract* and did not specifically indicate Humana's process for meeting the requirements. Many of the policies contained information related to Medicare or to other lines of business and were not specific to South Carolina. These specific issues are explained in the applicable sections of this report. The procedure section of each policy should be reviewed to 1) expand internal procedures or protocols, 2) outline steps currently in place but not documented within existing policies, or 3) indicate steps that need to be taken internally to accomplish the intent of the Contract language as applicable.

Onsite discussion detailed the standards specific to Humana's organizational structure and staffing requirements. It was reported that key positions are in phases of recruitment with some offers of employment pending. The Utilization Review Staff, Case Management Staff, Quality Improvement (Coordinator, Manager, Director), Quality Assessment and Performance Improvement Staff, Member Services Manager, the Medical Director, and the Board-Certified Psychiatrist/Psychologist are either currently vacant or do not meet the South Carolina residency requirement.

The organization's Information System Capabilities Assessment (ISCA) documentation and online resources confirm that data security is a priority. The documentation demonstrates best practices are adhered to for both day-to-day operations and broader scenarios such as disaster planning.

The Humana Corporate Compliance Plan emphasizes the goal of creating a workplace environment in which ethics are integral in the day-to-day operations with regards to ethical conduct, enabling the effective identification of ways to address foreseeable risks, promptly respond to new legal or regulatory exposures, and achieve business objectives in an appropriate manner. The Compliance Committee is chaired by the Chief Compliance Officer and includes members who have decision-making authority and

responsibility throughout the organization. Oversight, monitoring, and auditing activities include internal monitoring and audits, risk-based assessments, and as appropriate, external monitoring and auditing to evaluate Humana's compliance with state and federal requirements and the overall effectiveness of the Compliance Program. The Special Investigations Unit (SIU) Anti-Fraud Plan details Humana's processes for detection, investigation, and prevention of suspected fraud and abuse and to ensure ethical conduct for all lines of business.

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

Humana follows the National Committee for Quality Assurance (NCQA) credentialing standards and documents processes and requirements for initial credentialing and recredentialing in policies. The timeframe for processing credentialing applications is confusing when comparing corporate Policy (CORE Credentialing and Recredentialing (21st ed))-001A and Policy (CORE Credentialing and Recredentialing)-001. Also, CCME could not identify Humana's process and timeframe for reporting any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program to SCDHHS.

It was noted that Humana does not have a local Credentialing Committee as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.* Humana staff confirmed there is no South Carolina representation on the Corporate Credentials Committee.

Issues identified in individual practitioner credentialing files were related to the dates of approval notification letters, failure to collect the formal collaborative agreement for nurse practitioners; unclear information on the Provider Credentialing Profile checklist; and lack of required evidence of verification of CLIA for providers who indicated laboratory services are conducted in their offices. Issues noted in organizational provider credentialing files were related to lack of attestation; not verifying liability coverage; dates of approval notification letters; and untimely CLIA verification.

Appropriate processes are in place to monitor provider network access and availability. A recent network adequacy report indicated network compliance for all providers with the exception of a few specialties. However, recruiting and contracting efforts are underway to increase the number of network providers of the identified specialties.

Adequate processes have been established for initial and ongoing provider education, with adjustments made as necessary to continue provider education while COVID-19

restrictions are in place. Forms include virtual and online presentations, newsletters, provider portal updates etc. The Provider Manual serves as a rich resource for providers. Humana ensures members' needs are met through a culturally competent provider network. Activities to assess membership needs are in place, and staff and providers are educated about cultural competence. CCME could not identify Humana's processes for monitoring provider compliance with medical record documentation standards or for evaluating coordination of care between providers.

Processes for the review and adoption of preventive health guidelines and clinical practice guidelines are appropriate, although CCME noted the current guidelines do not include the American Academy of Pediatrics/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the Prevention Task Force.

Member Services

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

Humana has policies and procedures that define and describe member rights and responsibilities as well as methods of notifying members of their rights and responsibilities. New members will receive a welcome packet that includes instructions for contacting Member Services, selecting a primary care provider (PCP), and initiating services.

Members will have access to information and resources in the Member Handbook, on the website when it becomes available, and in member newsletters to help them use their benefits. However, some information in the Member Handbook regarding copayments and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Preventive services was limited or inconsistent.

The Member Handbook provides the toll-free telephone number, information, and descriptions for Member Services and the 24-Hour Nurse Advice Line. The plan will provide information on preventive health guidelines and health information on the website and in newsletters, and members will be encouraged to obtain recommended preventive services.

Processes for grievance handling and resolution are documented throughout policies, the Member Handbook, and the Provider Manual.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Humana provided the Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description, 2021 and a copy of the Quality Improvement (QI) work plan template and several QI policies. The program description provided the goals and objectives for the QI program; however, it did not address the scope of the program or include details regarding the utilization data Humana plans to monitor.

The Quality Assurance Committee (QAC) is the local committee responsible for the development and implementation of Humana's QI program in South Carolina. Humana's South Carolina Medicaid Medical Director will chair the QAC. Voting members include Humana's executives, medical and quality directors, and other managers. Medical and behavioral health network providers will be included as non-voting members. It is recommended Humana consider including the network providers as voting members of the QAC.

Humana provided a sample of the 2021 Quality Assessment and Performance Improvement Program work plan. The sample work plan included the activities, objectives, goals, responsible parties and the frequency or timeframe for completion of activities. The work plan will be updated as needed and annually at a minimum.

Humana will use the Stars Quality Report, which provides a list of members in their care that have a known gap in care. The Stars Quality Report is delivered via in-person visits, self-service access to a provider reporting system, mail, and secure fax. Physician Performance will be monitored according to policy (NNO 702-040 Physician Performance Measurement)-007. However, this policy only addressed the Medicare Advantage line of business.

Humana will assess the effectiveness of the QI program and the impact on the Population Health Management strategy annually. The evaluation will outline the accomplishments, analyze data and outcomes compared to goals, and identify barriers that could have contributed to not meeting objectives.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Humana will contract with an NCQA-licensed organization to conduct the HEDIS audit. Policy (Performance Measures)-005 (HUM-SC-QM-005-01) provides the process for

collection and reporting of performance data. This policy incorrectly contains references to Medicare requirements.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled. The QI Program Description contains a paragraph on page 42 titled Performance Improvement Projects, however; this section only included SCDHHS' expectations for performance improvement projects. Humana has a policy (PIP) (HUM-SC-MCD-QM-002-01) titled Performance Improvement Projects, that only includes roles and responsibilities. This policy mentions the Quality Director will work with Medicaid and Quality Improvement leadership to develop meaningful topics that consider the prevalence of a condition in the member population. This policy fails to include the details of how the performance improvement project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project. Humana provided the Performance Improvement Project template as an example of how performance improvement projects will be documented. This template meets the requirements. However, the template should also include statistical evidence if sampling is used for a project and the barriers and interventions documented on a separate page.

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)

The Utilization Management (UM) Program Description outlines the purpose, goals, objectives, and staff roles for physical health and behavioral health. Humana has several policies and documents that describe and define UM service areas.

The position of Transition Coordinator, required by the *SCDHHS Contract, Section 5.6.2*, has not been designated. During the virtual onsite, Humana staff reported recruitment efforts are in progress.

Appropriate reviewers will conduct service authorization requests using guidelines from Milliman Clinical Guidelines (MCG), SC Medicaid manuals, behavioral health guidelines from the American Society of Addiction Medicine (ASAM), and other established criteria. Humana has established policies defining processes for handling appeals of adverse benefit determinations. Several documentation issues were noted related to definitions, processes, and timeframes for member appeals.

The Care Management Program Description-004A and policies document care management processes and services provided. However, the requirements for Targeted Care Management services could not be identified.

A Fraud, Research, Analytics and Concepts (FRAC) document, UM Data Plan, and UM Program Description were submitted to review Humana's approach for evaluating over and under-utilization. However, these documents did not include a defined timeline for utilization data analysis, specific areas of interest (readmission, ER rates, pharmacy, etc.), who will set target rates, who will assist with monitoring and interventions, and plans to mitigate when issues are identified.

Delegation

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

Humana has delegation agreements with several entities and retains accountability for each delegated service. Prior to execution of a delegation agreement, a pre-delegation review is conducted to assess each entity's program, associated policies and procedures, staffing capabilities, and performance record prior to the entity performing the delegated activity. Performance of delegated entities is monitored annually.

The Delegation Policy attached to Policy (Delegation)-001 defines processes for delegation approval but does not fully address requirements for sub-delegation. Also, the policy does not address ongoing queries of the Office of Inspector General List of Excluded Individuals and Entities and the System for Award Management.

Table 1, Scoring Overview, provides an overview of the scoring for the Readiness Review. 176 of 204 standards received a score of "Met." There were 19 standards scored as "Partially Met" and nine standards related to staffing and credentialing received a "Not Met" score.

Table 1: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2021	32	1	7	0	0	40	80%
Provider Services							
2021	68	5	2	0	0	75	91%
Member Services							
2021	29	3	0	0	0	32	91%

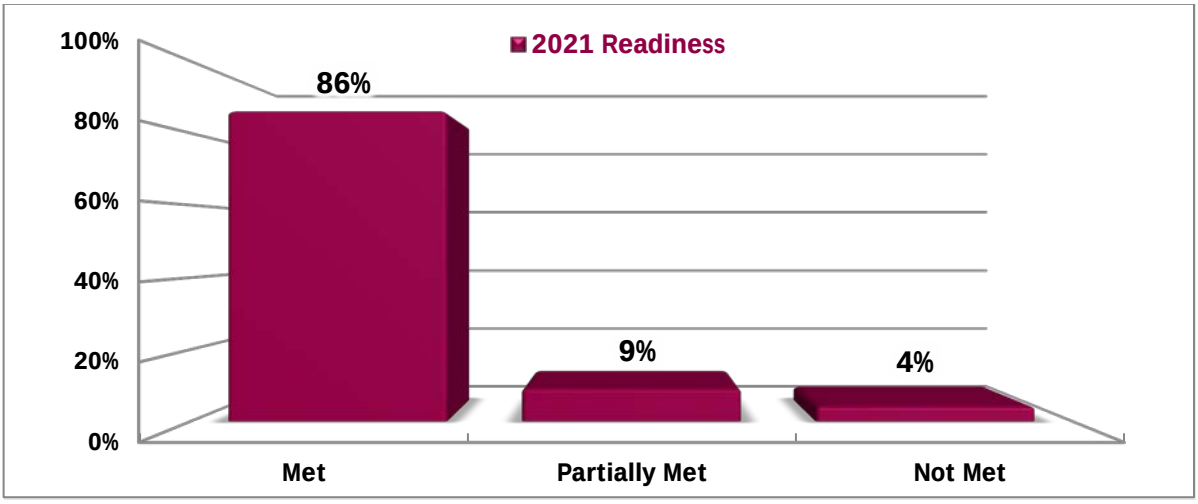
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Quality Improvement							
2021	10	3	0	0	0	13	77%
Utilization Management							
2021	36	6	0	0	0	42	86%
Delegation							
2021	1	1	0	0	0	2	50%
Totals							
2020	**176**	**19**	**9**	**0**	**0**	**204**	**86%**

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

Conclusions

Overall, there were issues with Humana's staffing and credentialing that did not meet the requirements set forth in *42 CFR Part 438 Subpart D* and the QAPI program requirements described in *42 CFR § 438.330* and the *SCDHHS Contract*. The Readiness Review shows that Humana has achieved "Met" scores for 86% of the standards reviewed. As the following chart indicates, 9% of the standards were scored as "Partially Met," and 4% of the standards scored as "Not Met."

Figure 1: Readiness Review Overall Results



Scores were rounded to the nearest whole number

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

- While policies and procedures are in place, many of the policies and procedures only included the contract language directly from the *SCDHHS Contract* and did not specifically indicate Humana's processes for addressing the requirements.
- Humana's personnel resources are not, with seven key positions currently in phases of recruitment but not filled.
- Humana does not have a local Credentialing Committee. The Corporate Credentials Committee makes all credentialing determinations; however, there is no South Carolina representation on the corporate committee.
- Humana follows National Committee for Quality Assurance (NCQA) standards for provider credentialing and recredentialing. Issues noted in credentialing files indicate Humana does not follow all additional credentialing requirements specified in the *SCDHHS Contract* and in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations*.
- Practitioner access standards are compliant with contractual requirements. A few Status 1 provider specialties do not meet the established threshold, but Humana has identified this and is working to recruit additional providers to close network gaps.
- Appropriate processes are in place for initial and ongoing provider education.
- Processes for review and adoption of preventive health and clinical practice guidelines are appropriate. Humana has not yet approved the AP/Bright Futures guidelines or any general guidelines for Well Child Care.
- Humana does not have an established policy or formal documented process for evaluating coordination of care between providers.
- Some information in the Member Handbook regarding copayments and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Preventive services was limited or inconsistent.
- The process for notifying members of changes in benefits 30 days before the effective date could not be identified in the Member Handbook, a letter template, a policy, or other document.
- Policy (Member Surveys) HUM-SC-QM-007-01 does not include the Children with Chronic Conditions survey.
- Documentation issues for filing and handling grievances were identified.
- The QI Program Description does not address the scope of the program or include details regarding the utilization data Humana plans to monitor.
- Medical and behavioral health network providers will not be included as voting members on the Quality Assurance Committee.

- The Performance Measure policy (HUM-SC-QM-005-01) incorrectly referenced Medicare requirements.
- The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled.
- Policy (NNO 702-040 Physician Performance Measurement)-007 contains *SCDHHS Contract* references; however, it does not include the specific process for monitoring SC Medicaid provider performance.
- Determination letter templates are written in language that is easily understood by a layperson.
- The Member Handbook and Provider Manual do not include information that service authorization decisions can be extended by 14 days.
- The Utilization Management Program does not have oversight from a Medical Director and Behavioral Health Medical Director.
- Information in the Member Handbook and Provider Manual about hysterectomies, sterilizations, and abortions is limited and does not include specific requirements for coverage of these procedures. Also, Humana does not have a policy or process for how hysterectomies, sterilizations, and abortions will be handled by the health plan.
- The UM Program Description does not include a description of post stabilization services.
- Documentation issues with appeals definitions, procedures and timeframes are noted.
- Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B have incomplete State fair Hearing information.
- Processes for Targeted Care Management (TCM) services are not documented.
- A Transition Coordinator has not been designated.
- There was no documentation provided specifying how Humana will monitor for and detect over- and underutilization.
- Humana retains accountability for delegated services and monitors the delegated entity performance.
- The Delegation Policy does not fully address requirements for sub-delegation and does not address queries of the OIG LEIE and the SAM on an ongoing basis.

Recommendations and Opportunities for Improvements

Areas needing corrections and recommendations include:

- Complete a comprehensive review of policies and procedures and add Humana's processes to accurately reflect steps currently in place or that need to be in place to demonstrate compliance with the *SCDHHS Contract*.
- Finalize the recruitment process to ensure the current vacant positions are filled.
- Establish a local Credentialing Committee to meet the requirements specified in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.
- Revise credentialing processes to meet not only the NCQA credentialing standards but also all additional credentialing requirements specified in the *SCDHHS Contract* and in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations*.
- Continue to work toward closing identified network gaps.
- Ensure the adoption of appropriate guidelines for Well Child Care.
- Establish and implement a policy for evaluating coordination of care between providers.
- Edit the Member Handbook and Policy (UM- Core Benefits and Services)-007, to be consistent with Humana's policy regarding copayments.
- Correct policy (Member Survey) HUM-SC-QM-007-01 to include the Children with Chronic Conditions version of the CAHPS survey.
- Include information in the Member Handbook, a letter template, a policy, or other document that members will be informed of benefit changes in writing 30 days before the effective date.
- Correct the documentation issues with grievance procedures.
- Update the QI Program Description and include the program's scope and the utilization data Humana plans to monitor.
- Update the QI Program Description and policy (PIP) HUM-SC-MCD-QM-002-01 to include details regarding how performance improvement project topics are developed or selected, data sources, and the steps needed for approval.
- Update policy (NNO 702-040 Physician Performance Measurement)-007 and include the specific for monitoring SC provider performance.
- Consider including network providers as voting members of the Quality Assurance Committee.

- Update the performance improvement project template to include evidence of the statistical testing if sampling is used, separate the interventions and barriers documentation, and include the type of intervention.
- Update the information in the Member Handbook and Provider Manual regarding the requirements for hysterectomies, sterilizations, and abortions, and develop a process for how Humana will handle hysterectomies, sterilizations and abortions that meets the state and federal requirements.
- Correct documentation issues with appeals definitions, procedures, and timeframes.
- Document Humana's process for ensuring Targeted Care Management services are provided to the identified population.
- Create a policy for detecting over- and under-utilization.
- Edit the Member Handbook and Provider Manual to include information that service authorization decisions can be extended by 14 days.
- Document that participating network providers are members of the Medicaid Managed Care (MMC) Committee.
- Include a description for post stabilization services in the UM Program Description.
- Include State Fair Hearing information in Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B.
- Continue recruitment efforts for a Transition Coordinator.
- Revise the Delegation Policy to fully address requirements for sub-delegation and ongoing monitoring of the OIG LEIE and SAM.

METHODOLOGY

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

On February 1, 2021, CCME sent notification to Humana that the readiness review was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Humana 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 on February 15th and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. The desk review also included a review of credentialing files.

The second segment was a virtual onsite review conducted on April 6, 2021 and April 7, 2021. 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 Humana staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

The EQR findings are summarized below and are based on the regulations set forth in *42 CFR Part 438 Subpart D*, the QAPI program requirements described in *42 CFR § 438.330,* and the contract requirements between Humana and SCDHHS. Strengths, weaknesses, and recommendations are identified where applicable. Areas of review were identified as meeting a standard "Met," acceptable but needing improvement "Partially Met," failing a standard "Not Met," "Not Applicable," or "Not Evaluated," and are recorded on the tabular spreadsheet (*Attachment 3*).

A. Administration

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

Humana has in place written policies and procedures stating its commitment to compliance with applicable federal and state standards. Many of the policies reviewed contained wording directly from the *SCDHHS Contract* and did not specifically indicate Humana's process for meeting the requirements. Many of the policies contained information related to Medicare or to other lines of business and were not specific to South Carolina. These specific issues are explained in the applicable sections of this

report. The procedure section of each policy should be reviewed to 1) expanded internal procedures or protocols, 2) outline steps currently in place, but not documented within existing policies, or 3) indicate steps that need to be taken internally to accomplish the intent of the Contract language as applicable.

Onsite discussion detailed the standards specific to Humana's organizational structure and staffing requirements. It was reported that key positions are in phases of recruitment with some offers of employment pending. The organizational chart outlines operational relationships for staff and lines of business collaboratively for Humana's South Carolina Market, Shared Services, and Medicaid Services roles. The Utilization Review Staff, Case Management Staff, QI (Coordinator, Manager, Director), QAPI Staff, Member Services Manager, Medical Director, and the Board-Certified Psychiatrist/Psychologist are either currently vacant or do not meet the South Carolina residency requirement. Based on these findings, it appears Humana's personnel resources are not sufficient.

Humana's ISCA documentation and online resources confirm that data security is a priority. The documentation demonstrates best practices are adhered to for both day-to-day staff operations and broader scenarios such as disaster planning. Additionally, Humana performs monitoring and auditing of the services they contract to business partners. Finally, staff is often seen as the weakest link in organizational security. In addition to regular training exercises, Humana's documentation states that they take additional measures to update staff and keep them informed with regular security related emails, intranet articles, and a yearly cyber security awareness event.

The Humana Corporate Compliance Plan emphasizes the goal of creating a workplace environment in which ethics are integral in the day-to-day operations with regards to ethical conduct, enabling the effectively identification of and ways to address foreseeable risks, promptly respond to new legal or regulatory exposures, and achieve business objectives in an appropriate manner. The Compliance Committee is Chaired by the Chief Compliance Officer and includes members who have decision-making authority and responsibility throughout the organization.

The Governance, Risk, and Compliance (GRC) Working Groups provide oversight to the monitoring and auditing activities within Humana. This includes internal monitoring and audits, risk-based assessments and, as appropriate, external monitoring and auditing to evaluate Humana's compliance with state and federal requirements and the overall effectiveness of the Compliance Program. The SIU Anti-Fraud Plan details Humana's processes for detection, investigation, and prevention of suspected fraud and abuse for all lines of business.

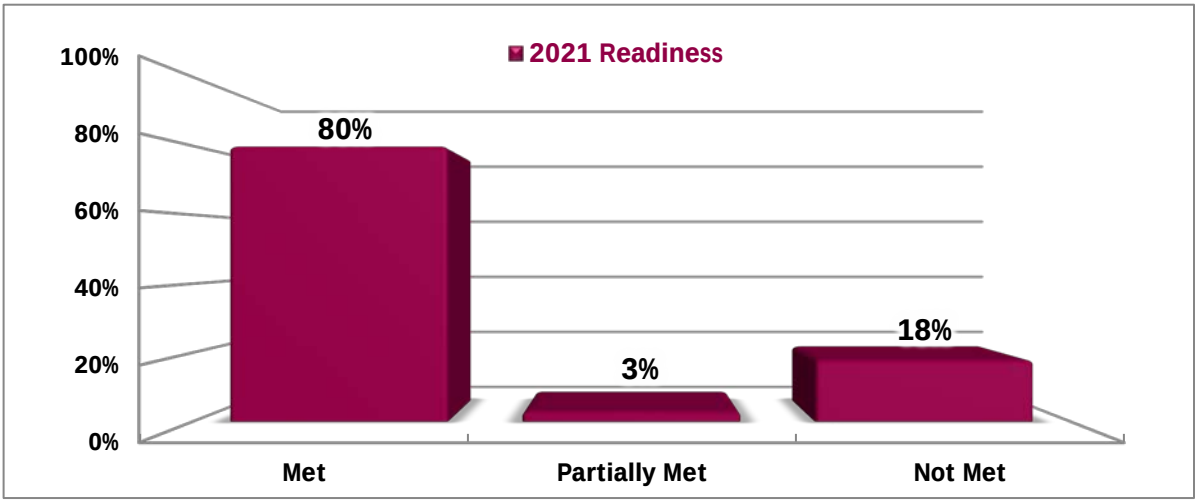
Humana enforces South Carolina's Pharmacy Lock-In Program and tracks the frequency with which some drugs are filled, monitors the pharmacies where drugs are filled, and

the number of doctor visits. In some cases, Humana may limit an enrollee to fill prescriptions at one pharmacy and from one doctor.

Humana associates, contractors, and vendors are governed by policies regarding all personal health information in accordance with the applicable federal and state laws, rules, and regulations. Training and support are provided to all Humana associates, subsidiaries, and affiliates.

Humana met 80% of the standards in the Administration section for the Readiness Review. Some standards related to staffing received a score of "Not Met." Figure 2, Administration Findings provides an overview of the scores for the Administration section of the review.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number

Table 2: Administration Standards Needing Improvements

SECTION	STANDARD	2021 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	Partially Met
Organizational Chart / Staffing	Utilization Review Staff	Not Met
	Case Management Staff	Not Met

SECTION	STANDARD	2021 REVIEW
Organizational Chart / Staffing	Quality Improvement (Coordinator, Manager, Director)	Not Met
	Quality Assessment and Performance Improvement Staff	Not Met
	Member Services Manager	Not Met
	Medical Director	Not Met
	Board Certified Psychiatrist or Psychologist	Not Met

The standards reflected in the table are only the standards that received a less than Met score.

Strengths

- Clear and easily accessible contact information is available to report fraud, waste, and abuse.
- The Ethics Every Day document provides examples of potential risks and practical measures to guard against ethics violations.
- Humana staff are provided with security information and updates in addition the organization's required security training.

Weaknesses

- While policies and procedures are in place, many of the policies and procedures only included the contract language directly from the SCDHHS Contract and did not specifically indicate Humana's process for addressing the requirements.
- Humana's personnel resources are not sufficient—seven key positions are currently in phases of recruitment but are not filled.

Quality Improvement Plans

- Complete a comprehensive review of policies and procedures and add Humana's processes to accurately reflect steps currently in place or that need to be in place to demonstrate Contract compliance.
- Finalize the recruitment process to secure the seven current vacant key positions.

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

CCME's review of Provider Services included credentialing and recredentialing processes and a review of credentialing files, adequacy of the provider network, provider education, preventive health and clinical practice guidelines, continuity of care, and practitioner medical records.

Provider Credentialing and Selection

Humana follows National Committee for Quality Assurance (NCQA) credentialing standards. Processes for initial credentialing and recredentialing of independent practitioners and organizational providers are documented in corporate Policy (CORE Credentialing and Recredentialing (21st ed))-001A. Policy (CORE Credentialing and Recredentialing)-001 is a supplement to the corporate policy and includes requirements specific to the SC Medicaid product. Onsite discussion confirmed Humana will follow the corporate timeframe of 30 calendar days for processing credentialing applications. However, Policy (CORE Credentialing and Recredentialing)-001 references the 60 calendar-day timeframe from the *SCDHHS Contract, Section 2.8.2.4.2* and does not indicate a 30 calendar-day timeframe will be followed instead. Also, CCME could not identify Humana's process and timeframe for reporting to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program.

Humana's Corporate Credentials Committee reviews and makes the final credentialing determination for each market, including South Carolina. Humana does not have a local Credentialing Committee, and staff confirmed there is no South Carolina representation on the corporate committee. The *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8,* requires each MCO to maintain a Credentialing Committee for which the MCO's Medical Director shall have overall responsibility. The corporate Credentials Committee may make initial credentialing determinations. However, the ultimate approval of all South Carolina Medicaid network providers is the responsibility of a plan-level Credentialing Committee, which should include South Carolina network provider representation from various specialties, including mid-level practitioners. A committee charter should be developed to specify the committee's roles and responsibilities, membership, meeting frequency, quorum, attendance requirements, etc.

Issues noted in the individual practitioner credentialing files reviewed included:

- For all files, the date on the approval notification letter was prior to the date of the Credentialing Committee's decision to approve the provider.
- One of two nurse practitioner files did not include the formal collaborative agreement between the nurse practitioner and the supervising physician, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.

- The Provider Credentialing Profile checklist indicated "acknowledged" for the National Practitioner Data Bank (NPDB) verification type for some credentialing files, without defining the meaning of this term in the "Verification Type Code" listing at the bottom of the checklist.
- For 12 files, there was no evidence of verification of Clinical Laboratory Improvement Amendments (CLIA) for providers who indicated laboratory services are conducted in their offices. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.

Issues noted in the organizational provider credentialing files included:

- Only one of 14 organizational provider credentialing files contained an attestation that the information submitted was accurate.
- None of the files included verification of liability coverage.
- The credentialing determination notification letters for all the reviewed organizational providers were dated prior to the credentialing determination date supplied by Humana.
- CLIA verifications for two hospitals were conducted after the credentialing decision date. Humana acknowledged this finding and responded that retraining of staff has been completed regarding this issue.

Availability of Services

Access requirements for PCPs, specialists, and hospitals are documented in policy and are compliant with contractual requirements. Humana conducts geo access analytics monthly and as needed for significant network changes. Monthly adequacy reports identify network gaps and activities to address network gaps are identified. Network availability will also be monitored through member satisfaction survey results, analysis of complaints/grievances, requests for out of network agreements, and Mystery Shopper Survey results. CCME could not identify the process for ensuring members have a choice of at least two contracted specialists accepting new patients within their geographic area.

The Humana Healthy Horizons in South Carolina Provider Support Plan (Network Development Plan) includes the Medicaid Network Adequacy Report with data as of November 10, 2020. The compliance rates for PCPs, required Status 1 specialists, and hospitals were included. CCME noted the compliance rates for several specialties were below the 90% benchmark. Humana responded that recruiting and contracting efforts are underway to increase the number of network providers of these specialties.

Provider Education

Humana's processes for initial and ongoing provider education are found in Policy (Provider Training)-001. Provider training is conducted within 30 days of a provider's contract effective date. Ongoing provider training is accomplished through monthly in-service visits to PCP offices, ad hoc provider site meetings/webinars, and regional provider training sessions, which will be held four times yearly. Additional provider education methods will include periodic provider newsletters, annual compliance training, updates to the online provider portal, mailings, faxes, and the Humana website.

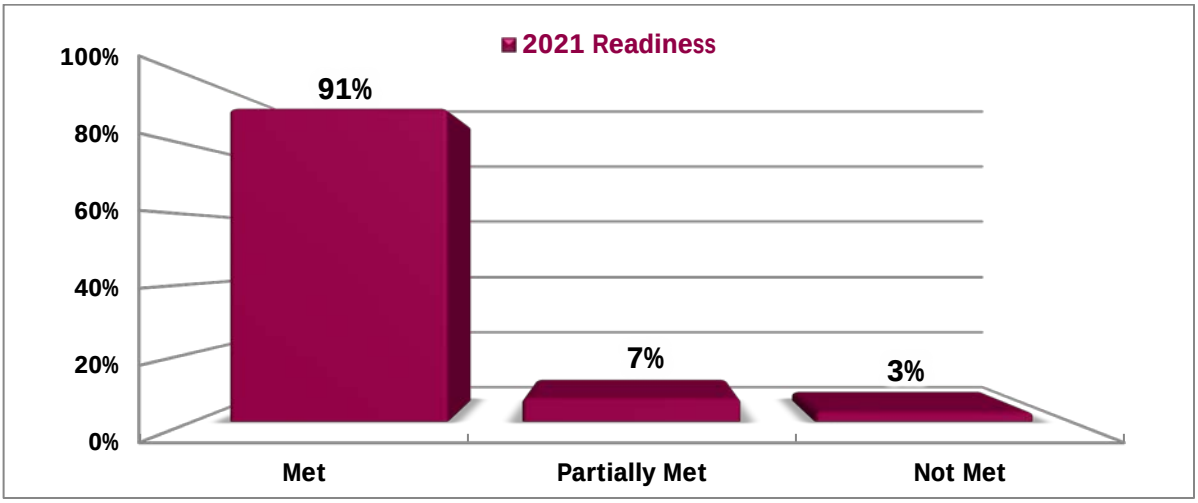
The Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description (QI Program Description) addresses Culturally and Linguistically Appropriate Services (CLAS). According to the QI Program Description, activities include identifying the ethnicity and racial make-up of membership; educating staff about cultural sensitivity and competency; providing member information in translated formats and through alternate telecommunications devices; and distributing cultural competency resources and training to providers. CCME noted a link in the Provider Manual to access the Humana Cultural Competency Plan on the website does not take the user to the Humana Cultural Competency Plan, and it could not be located elsewhere on the website by using the search functionality.

Humana has established processes for the review and adoption of preventive health guidelines and clinical practice guidelines. The guidelines are posted to Humana's website and information about the guidelines is included in the Provider Manual. Providers are informed that Humana will monitor provider implementation and use of the guidelines and will take corrective action as needed. CCME noted the guidelines do not include the American Academy of Pediatrics (AAP)/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the Prevention TaskForce. Humana acknowledged this finding and responded that Well Child Care guidelines will be approved and posted by July 1, 2021.

Although the Provider Manual and a Humana policy define standards for medical record documentation and indicate medical records must contain documentation of referrals and results of referrals, documentation of emergency and/or after hours encounters and follow-up, and consultation reports, CCME could not identify in a policy or other documents a process for evaluating coordination of care between providers.

As noted in *Figure 3: Provider Services Findings*, Humana achieved scores of "Met" for 91% of the Provider Services standards.

Figure 3: Provider Services Findings



Scores were rounded to the nearest whole number

Table 3: Provider Services Standards Needing Improvements

SECTION	STANDARD	2021 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met
	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	Not Met
	The credentialing process includes all elements required by the contract and by the MCO's internal policies	Partially Met
	Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Not Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met

SECTION	STANDARD	2021 REVIEW
Adequacy of the Provider Network	The MCO maintains a provider directory that includes all requirements outlined in the contract	Partially Met
Continuity of Care	The MCO monitors continuity and coordination of care between the PCPs and other providers	Partially Met

The standards reflected in the table are only the standards that received a less than Met score.

Strengths

- The Corporate Bold Gold Initiative focuses on the impact of food insecurity and social isolation and captures the impact on healthy days in communities.
- The Humana website includes the Cultural Competency Training 2021 document that provides information about culture and cultural competence, clear communication, various subcultures and populations, and strategies for working with seniors and people with disabilities.

Weaknesses

- Policy (CORE Credentialing and Recredentialing (21st ed))-001A, page 9, states the credentialing process should be completed within 30 days or as required by state or federal regulations, and onsite discussion revealed Humana will follow the 30-calendar day timeframe for processing credentialing applications. However, Policy (CORE Credentialing and Recredentialing)-001 includes the *SCDHHS Contract, Section 2.8.2.4.2* requirement that credentialing applications be processed within 60 calendar days. It does not indicate Humana will follow a 30-day timeframe for processing credentialing applications.
- CCME could not identify a policy or other document that addressed requirements from the *SCDHHS Contract, Section 11.12.11.7* to report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.
- Humana does not have a local Credentialing Committee, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*. Instead, Humana's Corporate Credentials Committee reviews and makes the final credentialing determination for each market/plan. There is no representation from South Carolina on this corporate committee.

- Issues noted in independent practitioner credentialing files included:
  - For all independent practitioner credentialing files reviewed, the approval notification letters were dated prior to the date of the Credentialing Committee's decision to approve the provider. Humana stated during onsite discussion that once the Medical Director approves Category I (or "clean") credentialing files, the approval letter is sent to the practitioner. CCME requested on two occasions the dates of Medical Director approval for the reviewed files. The information was not provided.
  - One of two nurse practitioner files reviewed did not include the formal collaborative agreement between the nurse practitioner and the supervising physician, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*.
  - For several credentialing files, the Provider Credentialing Profile checklist states "acknowledged" for the NPDB verification type. The term "acknowledged" is not defined in the "Verification Type Code" listing at the bottom of the checklist.
  - For 12 provider credentialing files, CCME did not identify evidence of verification of CLIA when the provider indicated laboratory services are conducted in their offices, as required by the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.*
- Review of credentialing files for organizational providers revealed the following issues:
  - 13 of the 14 files did not contain an attestation that the information submitted was accurate.
  - None of the files included verification of liability coverage. Humana responded that verification of liability coverage for organizational providers is not required by NCQA, and although Humana requires organizational providers to have appropriate liability coverage, this is not verified at the time of credentialing.
  - The credentialing determination notification letters for all the reviewed organizational providers were dated prior to the credentialing determination date.
  - The CLIA verification for two hospitals were conducted after the credentialing determination date—one was 11 months after the decision date, and the other was five months after the decision date.
- Neither Policy (SC Medicaid Network Availability and Access)-004 nor the Network Development Plan address Humana's plan to ensure members have a choice of at least two contracted specialists who are accepting new patients within their geographic area.
- Page 60 of the Provider Manual states Humana's Cultural Competency Plan can be viewed at on the Humana.com website. However, the hyperlink in the Provider Manual

takes the user to a page with a heading of "Language assistance and diversity" that only covered topics related to interpreters and translation services. The Humana Cultural Competency Plan was not located on this page. Additionally, the Humana Cultural Competency Plan could not be located on the website by using the search functionality.

- The draft Provider Directories submitted for review did not include completed cultural competency training, as required by the *SCDHHS Contract, Section 3.13.5.1.1*.
- CCME noted items "p" and "s" in the list of provider training topics on page 2 of Policy (Provider Training)-001 are incomplete. Also, page 3 of the policy includes a reference to another state's Provider Manual.
- CCME's review of the submitted preventive guidelines and the guidelines listed on the Humana.com website did not include the AAP/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the Prevention TaskForce Preventive Care Recommendations.
- The process for monitoring coordination of care between providers could not be identified program descriptions or in policies.

Quality Improvement Plans

- Revise an appropriate policy to define the process Humana will follow for reporting to SCDHHS any network providers that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.
- Establish a local (plan level) Credentialing Committee to make the final credentialing determinations for the South Carolina Medicaid provider network. Ensure the MCO Medical Director oversees and has overall responsibility for the committee's activities and that the committee includes network provider representation from various specialties, including mid-level practitioners. A committee charter should be developed to specify the committee's roles and responsibilities, membership, meeting frequency, quorum, attendance requirements, etc.
- For independent practitioner credentialing files, ensure:
  - Files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.
  - Files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician.
  - Files contain evidence of verification of the CLIA when the provider application indicates laboratory services are conducted in the provider's office/location.

- For organizational provider credentialing files, ensure:
  - Files include a signed statement that the information submitted is accurate to the best of the signee's knowledge.
  - Files include verification of liability insurance required by Humana.
  - Files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.
  - CLIA verification is conducted prior to the credentialing determination.
- Include cultural competency training completed by providers in the Provider Directory, as required by the *SCDHHS Contract, Section 3.13.5.1.1*.
- Document the process for monitoring coordination of care between providers in a policy, including methods of monitoring and assessment, processes for addressing any identified deficiencies, etc.

Recommendations

- Because credentialing application processing for SC providers will follow the corporate timeframe of 30 calendar days, revise the "Policies and Procedures" section of Policy (CORE Credentialing and Recredentialing)-001 to indicate a 30-day timeframe will be followed for SC provider credentialing.
- Update the "Verification Type Code" list on the Provider Credentialing Profile checklist to include the term "acknowledged" and what that means in relation to the NPDB query.
- Revise either Policy (SC Medicaid Network Availability and Access) 004 or the Network Development Plan to address Humana's plan to ensure members have a choice of at least 2 contracted specialists who are accepting new patients within the members' geographic area.
- Ensure the hyperlink to the Humana Cultural Competency Plan listed in the Provider Manual is correct and that the Humana Cultural Competency Plan is easily located on the website.
- Correct the issues noted on pages two and three of Policy (Provider Training)-001.
- Ensure Humana's approved preventive health guidelines include a guideline for Well Child Care screenings according to the AAP periodicity schedule, as required by the *SCDHHS Contract, Section 4.2.10.2*. The guideline should be included in Policy QM-001-17.

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

CCME's review of Member Services focused on areas such as member rights and responsibilities, member education and informational materials, Member Satisfaction Surveys, and grievance procedures. The member-facing website was not launched at the time of this EQR thus, Member Services requirements for online access could not be reviewed. Humana has policies and procedures that define and describe Member Services activities and provide guidance to staff for performing those activities.

Policy (Member Rights)-028 documents how Humana advises members of their rights and responsibilities and how these rights are protected. Members are informed of their rights and responsibilities from the Member Handbook and member rights are communicated in other member materials. Onsite discussions revealed staff members are trained to access the Member Handbook for a complete list of Member Rights and Responsibilities and to refer to it when members have questions about their rights.

New members will receive a Welcome Kit that includes a welcome letter, a plan booklet providing an overview of benefits and services, instructions to access the Member Handbook and the Provider Directory, member education materials, and information about member rights. Additionally, new members will receive a copy of the Member Handbook and an I.D. Card. A welcome phone call will follow to discuss materials in the Welcome Kit and to offer any assistance.

The Member Handbook provides useful information and is written below a 6th grade reading level, allowing it to be easily understood. It is available in Spanish and alternate formats including large font, audio, and Braille. The Member Handbook educates members about their rights and responsibilities, preventive health and appointment guidelines, instructs members about how to access benefits, and provides key contact information.

Humana staff indicated the plan has waived copayments for all members of any age and for all covered benefits. However, documentation on pages 13 and 19 in Policy (UM- Core Benefits and Services)-007, indicates that copayments are allowed for members aged 19 and older. The Member Handbook (page 36) indicates there is a $3.40 copayment for medications listed in the PDL for members aged 19 and older.

The EPSDT information in the Member Handbook is very brief, exam components are simply bulleted in a list, and there is a statement mentioning that EPSDT services are for members from birth to their 21st birthday. Additionally, members are instructed to contact their PCP, Member Services, or Humana.com for more information about EPSDT

services. Unlike the Provider Manual, the Member Handbook does not provide a description of preventive exam components, the recommended age-appropriate exam intervals, or references to the American Academy of Pediatrics (AAP) and Bright Futures Periodicity Schedule that can educate and assist members in obtaining these services.

Humana is in the process of finalizing member newsletters, health and wellness materials, and electronic communications. Materials and information will be accessible from the website and the member's portal, and may be delivered via email, social media platforms, and free text messages. Humana ensures member program materials are written in a clear and understandable manner according to requirements in the *SCDHHS Contract, Section 3.15*.

Member Services staff are available per contract requirements via a toll-free number, which routes calls to Interactive Voice Response menus that allow callers to reach staff during the hours of 8:00 a.m. to 6:00 p.m., Monday through Friday. The Nurse Advice Line is available 24 hours a day.

Policy HUM-SC-QM-007-01, Member Surveys, describes Humana's process for conducting, monitoring, and analyzing member surveys. However, it does not include the Children with Chronic Conditions version of the CAHPS survey.

Grievances

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

Humana processes grievance for benefits and services that are provided by the plan. Humana's staff and the Member Handbook confirmed the plan does not provide dental benefits to members and does not process grievances for dental services. However, the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C document states, "This process applies to medical and dental."

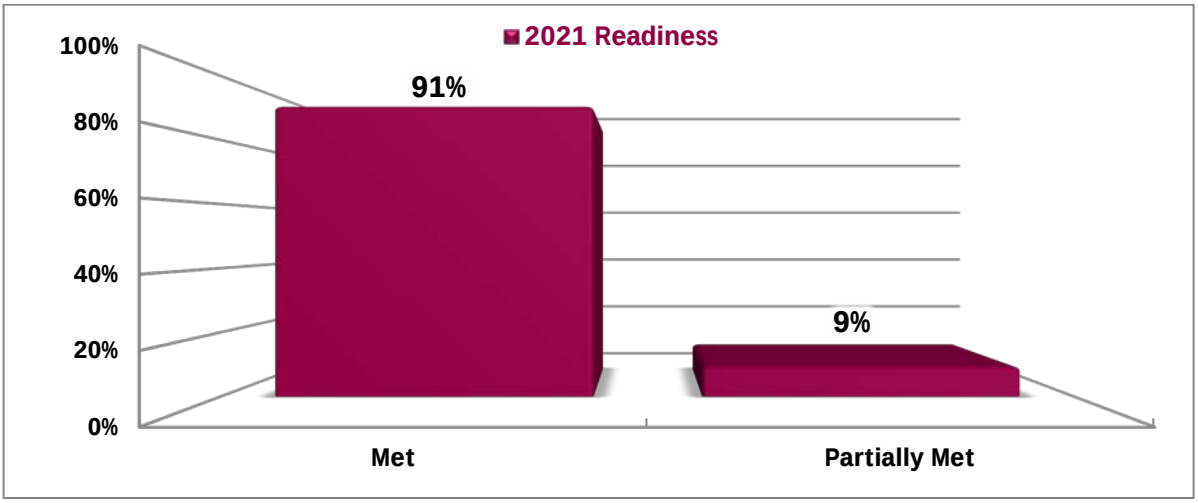
The following documentation issues for filing and handling grievance were identified:

- Grievance acknowledgement timeframes are documented in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document. However, acknowledgment timeframes are not included in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.
- The South Carolina Medicaid Grievance First Level Review-001F document (page 8) incorrectly documents the grievance filing timeframe as "30 calendar days." According to requirements in *SCDHHS Contract, Section 9.1.1.2.1*, grievances can be filed at any time.

- The table of "Important Phone Numbers" on page 26 of the Member Handbook lists 1-800-372-2973 as the number to contact for grievances related to Medicaid Services. However, members are informed to call Enrollee Services (1-866-432-0001) on page 60 of the Member Handbook.

As noted in *Figure 4: Member Services Findings*, 91% of the standards for Member Services are scored as "Met" and 9% are scored as "Partially Met."

Figure 4: Member Services Findings



Scores were rounded to the nearest whole number

Table 4: Member Services Standards Needing Improvements

SECTION	STANDARD	2021 REVIEW
Member Program Education	Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services	Partially Met
	Members are informed in writing of changes in benefits and changes to the provider network	Partially Met

SECTION	STANDARD	2021 REVIEW
Grievance	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: Procedures for filing and handling a grievance	Partially Met

The standards reflected in the table are only the standards that received a score less than a Met.

Strengths

- Member materials, preventive health guidelines, and other general information will be accessible on the website and the member portal, and will also be delivered via email, social media platforms, and free text messages.

Weaknesses

- Humana staff indicated the plan has waived copayments for all members of any age and for all covered benefits. However, Policy (UM- Core Benefits and Services)-007, indicates that copayments are allowed for members aged 19 and older. Also, the Member Handbook mentions a co-payment for medications.
- Documentation of Humana's process for notifying members of changes in benefits or services could not be identified in the Member Handbook or other documents.
- The Member Handbook provides limited information on EPSDT preventive services and does not adequately educate members about this service. It does not define or describe EPSDT services such as exam components, the recommended age-appropriate exam intervals, or reference the AAP/Bright Futures Periodicity Schedule as a resource.
- Policy (Member Surveys) HUM-SC-QM-007-01 does not include the Children with Chronic Conditions survey.
- Humana does not process grievances for dental services. However, the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C document states, "This process applies to medical and dental."
- The following documentation issues for filing and handling grievance were identified:
  - Grievance acknowledgement timeframes are documented in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document. However,

acknowledgment timeframes are not included in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.

- The South Carolina Medicaid Grievance First Level Review-001F document (page 8) incorrectly documents the grievance filing timeframe as "30 calendar days." According to requirements in *SCDHHS Contract, Section 9.1.1.2.1* grievances can be filed at any time.
- The table of "Important Phone Numbers" on page 26 of the Member Handbook lists 1-800-372-2973 as the number to contact for grievances related to Medicaid Services. However, members are informed to call Enrollee Services (1-866-432-0001) on page 60 of the Member Handbook.

Quality Improvement Plans

- Include information in the Member Handbook that members will be informed of benefit changes in writing 30 days before the effective date as required by the *SCDHHS Contract, Section 3.13*. Develop a procedure that describes how Humana will meet this requirement.
- To adequately educate members about EPSDT services, edit the Member Handbook to include definitions, a description of required EPSDT examinations, and the recommended schedule for members to obtain age-appropriate services.
- Remove the references to dental in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C.
- The grievance acknowledgement timeframes listed in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document should be added to Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.
- Correct the grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document as required by the SCDHHS Contract, Section 9.1.1.2.1.
- Correct the grievance phone number listed in the Member Handbook, page 26.
- Edit Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E to include grievance acknowledgement timeframes.
- Edit Policy Grievance First Level Review 001F, Policy Grievance First Level Review-EXP 001C, and the Member Handbook to reflect that a grievance can be filed at any time.

Recommendations

- Edit the Member Handbook and Policy (UM- Core Benefits and Services)-007, to be consistent with Humana's policy regarding copayments.

- Edit the Member Handbook to correctly define the term "grievance" according to the *SCDHHS Contract, Section 9.1 (a).*
- Correct policy (Member Survey) HUM-SC-QM-007-01 to include the Children with Chronic Conditions version of the CAHPS survey.

D. Quality Improvement

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

Humana provided the Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description, 2021. This program description provides the goals and objectives for the Healthy Horizon program. Some of the goals included: developing clinical strategies and programs that look at the whole person and integrates behavioral and physical health. The QI Program Description does not address the scope of the program. Page eight of the program description, under letter E, Quality Assessment and Performance Improvement Program Scope, only mentions "Humana provides Medicaid covered services to eligible Medicaid beneficiaries as a qualified Health Maintenance Organization." The program description was a draft and will be finalized after committee approval.

One of the goals and objectives listed in the QI Program Description is to provide a mechanism to detect both over- and underutilization. Per the QI Program Description, Humana will monitor utilization trends to identify potential over and underutilization issues. Further actions will be taken as warranted. There were no details included regarding the utilization data Humana plans to monitor. It is recommended that Humana include in the scope the specific details regarding how potential over- and underutilization issues will be identified.

On page 27 of the QI Program Description, under the section titled "Pharmacy Management," it notes members receive a Humana-designed Smart Summary RX bulletin offering guidance in changing medications to those with a lower co-payment while maintaining the same efficacy. It was unclear during the onsite discussion if this would be a program/tool used for Humana's Medicaid members.

The Internal Board/Management Team has ultimate responsibility for the QI program. This team has delegated authority for oversight to the Corporate Quality Improvement Committee. The Quality Assurance Committee (QAC) is the local committee responsible for the development and implementation of Humana's quality improvement program in South Carolina. Humana's South Carolina Medicaid Medical Director will chair the QAC. Voting members include Humana's executives, medical and quality directors, and other managers. Medical and behavioral health network providers will be included as non-voting members. It is recommended Humana consider including the network providers as voting members of the QAC.

Humana provided a sample of the 2021 Quality Assessment and Performance Improvement Program work plan. The sample work plan included the activities, objectives, goals, responsible party, and the frequency or timeframe for completion. The work plan will be updated as needed and at least annually.

Humana will use The Stars Quality Report, which provides a list of members in their care who have a known gap in care. The Stars Quality Report is delivered via in-person visits, self-service access to a provider reporting system, mail, and secure fax.

Policy (NNO 702-040 Physician Performance Measurement)-007 contains the *SCDHHS Contract* references and lists the purpose of the policy as "This policy recognizes our strategic goals of continuously improving the efficiency and effectiveness of our networks." Under the section labeled "Policy and Procedure," there is an embedded PDF file labeled NNO 702-040 Physician Performance. This embedded PDF file is Humana's corporate policy for improving the efficiency and effectiveness of commercial and Medicare Advantage networks. This policy does not address the Medicaid line of business.

Humana will assess the effectiveness of the QI program and the impact on the Population Health Management strategy annually. The evaluation will outline the accomplishments, analyze data and outcomes compared to goals, and identify barriers that could have contributed to not meeting objectives.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Humana's policy (Performance Measures)-005 (HUM-SC-QM-005-01) provides the process for collecting and reporting performance data. Performance data will be collected through a combination of various sources such as surveys, medical records, and claims or encounter data. Humana contracts with an NCQA-licensed organization to conduct the HEDIS audit. On page four of this policy, under letter E, it incorrectly states, "All HEDIS, Health Outcomes Survey and CAHPS data will be reported consistent with Medicare requirements. All existing Part D metrics will be collected." This policy should be corrected and include the Medicaid requirements for collecting performance measures.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

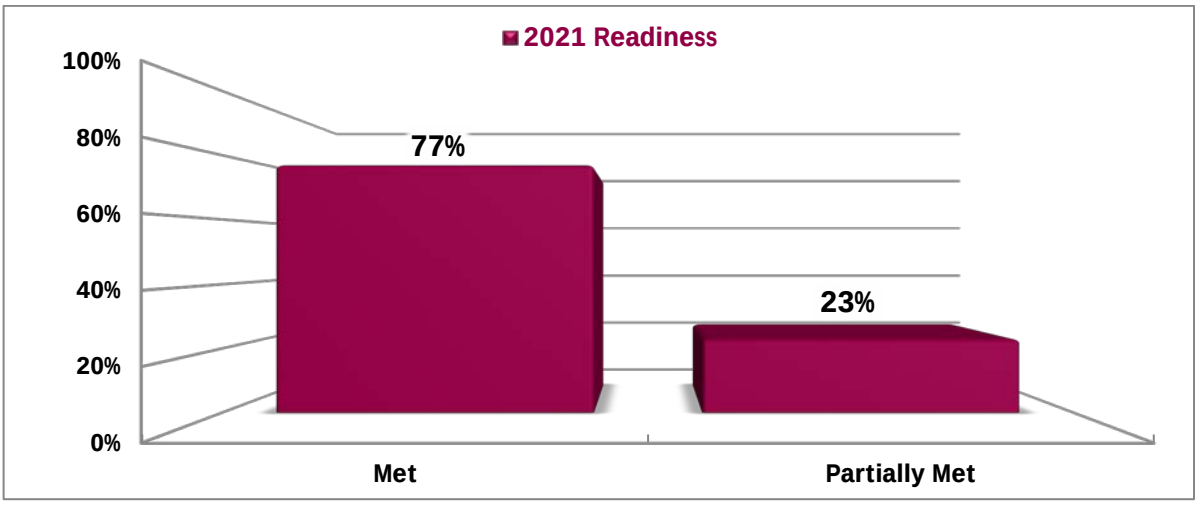
The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled. The QI Program Description contains a paragraph on page 42 titled, "Performance Improvement Projects." However, this section only included the State's expectations for performance improvement projects. Humana has a policy, (PIP) HUM-SC-MCD-QM-002-01, that only includes roles and responsibilities. This

policy mentions the Quality Director will work with Medicaid and Quality Improvement leadership to develop meaningful topics that consider the prevalence of a condition in the member population. This policy fails to include the details of how the performance improvement project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project.

Humana provided the Performance Improvement Project template as an example of how performance improvement projects will be documented. This template meets the requirements, however CCME provided a few recommendations. Page six contained the barriers and interventions to address any barriers. CCME recommends separating the interventions and barriers documentation and identify the type of intervention (provider, member, system etc.). This allows for better documentation of improvement strategies, ongoing strategies, and changes in the strategy. The CMS protocol requires documentation of statistical evidence. Humana should include a section in the Performance Improvement Project template that addresses statistical testing and presents the p-values from the tests.

For this Readiness Review, Humana received a "Met" score for 77% of the standards in the Quality Improvement section. The Partially Met scores were related to documentation in the QI Program Description, the Performance Improvement Project policy, and the Physician Performance Measurement policy.

Figure 5: Quality Improvement Findings



Scores were rounded to the nearest whole number

Table 5: Quality Improvement Standards Needing Improvements

SECTION	STANDARD	2021 REVIEW
The Quality Improvement (QI) Program	The MCO has a system in place for implementing a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Partially Met
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Partially Met
Provider Participation in Quality Improvement Activities	Providers will receive interpretation of their QI performance data and feedback regarding QI activities	Partially Met

The standards reflected in the table are only the standards that received a less than Met score.

Strengths

- Humana provided a sample of the 2021 Quality Assessment and Performance Improvement Program work plan. The sample work plan included all requirements and will be updated as needed.

Weaknesses

- The QI Program Description does not address the scope of the program. Page eight of the program description, under letter E, Quality Assessment and Performance Improvement Program Scope, only mentions "Humana provides Medicaid covered services to eligible Medicaid beneficiaries as a qualified Health Maintenance Organization."
- The QI Program Description does not include details regarding the utilization data Humana plans for monitor for potential over- and underutilization issues.
- Medical and behavioral health network providers will not be included as voting members on the Quality Assurance Committee.
- It was unclear if the Smart Summary RX bulletin discussed in the Pharmacy Management section of the QI Program Description would be a program or tool used for South Carolina Medicaid members.

- The QI Program Description outlines the various committees within the health plan. A description of the Health Services Organization National Committee was missing in the QI Program Description and the Pharmacy and Therapeutics committee was not included in the committee matrix on page 15.
- Policy (Performance Measures)-005 (HUM-SC-QM-005-01), page four, under letter E, incorrectly states, "All HEDIS, Health Outcomes Survey and CAHPS data will be reported consistent with Medicare requirements. All existing Part D metrics will be collected."
- The materials submitted by Humana lacked details regarding how the performance improvement projects will be handled.
- Policy (NNO 702-040 Physician Performance Measurement)-007 contains the *SCDHHS Contract* reference, however, does not include the specific process for monitoring South Carolina Medicaid provider performance.

Quality Improvement Plans

- Update Section E of the QI Program Description and include the program's scope.
- Update the QI Program Description and Policy HUM-SC-MCD-QM-002-01 to include details regarding how performance improvement project topics are developed or selected, data sources, and the steps needed for approval.
- Update policy (NNO 702-040 Physician Performance Measurement)-007 to include the specific processes for monitoring South Carolina provider performance.

Recommendations

- Include in the scope of the QI Program the specific details regarding how Humana will monitor utilization data to identify potential over- and underutilization issues.
- Consider including the network providers as voting members of the Quality Assurance Committee.
- Update the Pharmacy Management section of the QI Program Description to indicate whether the Smart Summary RX bulletin will be used for Medicaid Members.
- Include a description of the Health Services Organization National Committee and add the Pharmacy and Therapeutics Committee on the committee structure/matrix on page 15 of the QI Program Description.
- Correct the references to Medicare in policy (Performance Measures)-005 (HUM-SC-QM-005-01).
- Update the performance improvement project template to include evidence of the statistical testing if sampling is used, separate the interventions and barriers documentation, and include the type of intervention.

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)

CCME's review of Humana's Utilization Management (UM) Program included UM policies and procedures, medical necessity determination processes, pharmacy requirements, and the Care Management Program. The UM Program Description and policies provide guidance to staff conducting UM activities for physical health, behavioral health, and pharmaceutical services for members in South Carolina.

CCME noted two instances where Humana documented that dental services are provided by the plan. The UM Program Description states, "authorizations for dental services are reviewed for medical necessity by our dental services vendor," and Policy (South Carolina Medicaid Standard Appeal First Level)-001G mentions that, "this process applies to medical and dental" when referring to the standard appeal process. Humana staff confirmed that the plan does not provide dental benefits to members and does not handle appeals or service authorizations for dental services. It is advised that the documents be updated to clarify and or correct the misinformation.

Humana has several policies and documents that describe and define UM service areas, such as service authorizations, pharmacy, care management, appeals, and grievances. Many policies have similar or same names with an alphanumeric identifier at the end of the name and are comprised mostly of verbatim references from the *SCDHHS Contract*. For example, Policy (UM- Core Benefits and Services)-007 and the Specific Core Benefit Policy basically repeat references from the *SCDHHS Contract* and do not clearly explain Humana's process for meeting requirements for emergency and post stabilization services. Additionally, the Specific Core Benefit Policy does not have a title or policy heading and does not reference that it is to be used in conjunction with Policy (UM-Core Benefits and Services)-007.

The Medical Director and Behavioral Health Medical Director will be involved in UM and Quality activities with oversight over their respective areas. At the time of the onsite, both positions were vacant and recruitment efforts are in progress with possible pending offers.

Medical necessity reviews of service authorization requests will be conducted using guidelines from Milliman Care Guidelines (MCG), SC Medicaid manuals, medical coverage policies, and guidelines from the American Society of Addiction Medicine (ASAM). Humana will assess consistency in criteria application and decision-making through annual inter-rater reliability (IRR) testing for physician and non-physician reviewers, behavioral health staff, and pharmacy staff. The established passing score is 90% for non-physician reviewers and 85% for physicians.

Hysterectomies, sterilizations, and abortions are mentioned in the Member Handbook and Provider Manual as covered benefits. However, the information is limited and does not include the specific requirements noted in the SCDHHS MCO Policy and Procedure Guide, Section 4. Also, Humana does not have a policy or process for how hysterectomies, sterilizations, and abortions will be handled by the health plan.

Humana Pharmacy Services (HPS) is delegated to provide pharmacy benefit services for Humana. The most current version of the Preferred Drug List (PDL) will be used and will be made accessible on the website. The formulary list submitted for review, dated April 5, 2021, includes medications listed by label name, generic name, specialty status, and applicable limitations. HPS has processes in place to handle prior authorization requests for medications that are not on the PDL.

A Fraud, Research, Analytics and Concepts (FRAC) document, UM Data Plan, and UM Program Description were submitted to review Humana's approach for evaluating over and under-utilization. However, these documents did not include a defined timeline for utilization data analysis, specific areas of interest (readmission, ER rates, pharmacy, etc.), who will set target rates, who will assist with monitoring and interventions, and plans to mitigate when issues are identified.

The Care Management Program Description-004A describes Humana's approach to providing care management. The Care Management Program focuses on prevention, continuity, and coordination of care for medical and behavioral health needs and addressing issues related to social determinants of health. The Chronic Conditions and Management Program focuses on assisting members to manage chronic medical conditions. A description of Humana's process for providing Targeted Care Management services was not noted in the Care Management Program Description or any other document and Humana is advised to create a document reflecting the same. Humana staff reported a Transition Coordinator, required by the SCDHHS Contract, Section 5.6.2, has not been designated. During the virtual onsite, Humana staff reported recruitment efforts are in progress.

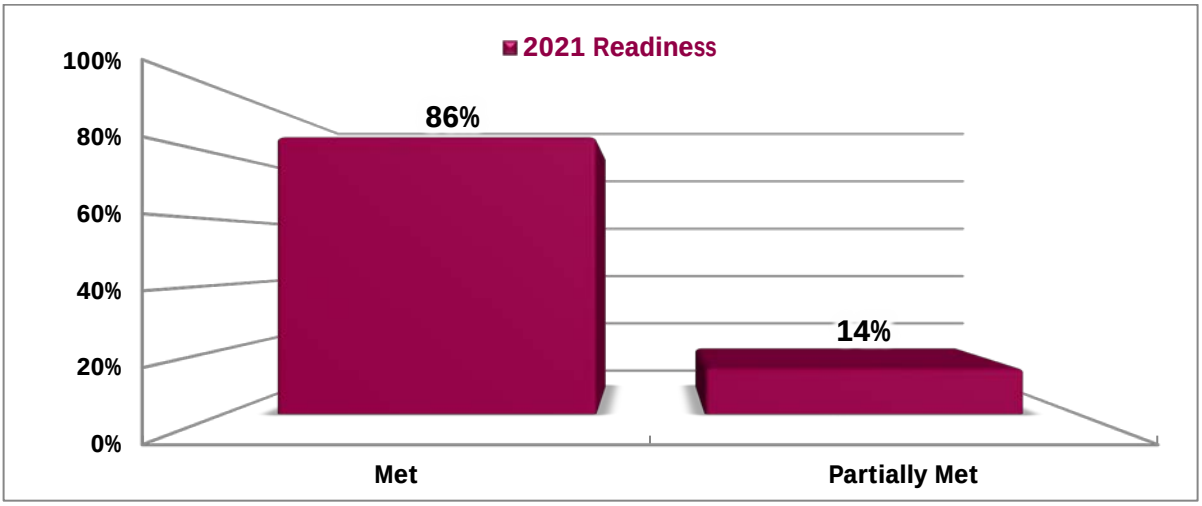
Appeals

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

Appeal determinations are made and resolution notices are provided within 30 calendar days of receipt for standard appeals and within 72 hours of receipt for expedited appeals. Determination letter templates include contractually required information and instructions will be written in language that can be easily understood by a layperson.

As noted in *Figure 6: Utilization Management Findings*, Humana achieved "Met" scores for 86% of the Utilization Management standards.

Figure 6: Utilization Management Findings



Scores were rounded to the nearest whole number

Table 6: Utilization Management Standards Needing Improvements

SECTION	STANDARD	2021 REVIEW
Medical Necessity Determinations	Coverage of hysterectomies, sterilizations, and abortions is consistent with state and federal regulations	Partially Met
Appeals	The definitions of an adverse benefit determination and an appeal and who may file an appeal;	Partially Met
	The procedure for filing an appeal	Partially Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met
Care Management and Coordination	The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Partially Met
Evaluation of Over/ Underutilization	The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	Partially Met

The standards reflected in the table are only the standards that received a less than Met score.

Strengths

- The Member Handbook informs members that a signed Authorization of Representative form is needed from a provider or another person to act on the member's behalf.
- Determination letter templates are written in language that is easily understood by a layperson.

Weaknesses

- The Member Handbook and Provider Manual do not include information that service authorization decision timeframes can be extended by 14 days when requested by the member or the plan, which is required by the *SCDHHS Contract* and documented in Policy UM-Timeliness of UM Determinations)-005.
- The Utilization Management Program does not have oversight from a Medical Director and Behavioral Health Medical Director. Humana explained the positions are vacant and recruitment efforts are in progress with possible pending offers to fill.
- CCME could not determine if network providers are included or will be included in discussions, evaluations, or updates related to UM Program activities at the plan-level. During the onsite, Humana staff explained the Medical Management Committee (MMC) includes network providers however, the UM Program Description and QI Program Description do not indicate that providers from the network are members of the MMC.
- Hysterectomies, sterilizations, and abortions are mentioned in the Member Handbook and Provider Manual as covered benefits. However, the information is limited and does not include the specific requirements noted in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4. Also, Humana does not have a policy or process for how hysterectomies, sterilizations, and abortions will be handled by the health plan.
- The UM Program Description describes emergency services but does not include a description of post stabilization services.
- The following issues with documentation of appeals definitions are noted:
  - The term "appeal" is not completely and clearly defined in the Key Words and Appeals sections of the Member Handbook. These sections of the Member Handbook do not specify that an appeal is a request to review an adverse benefit determination, as noted in the *SCDHHS Contract*.
  - The term "adverse benefit determination" is not defined in the Member Handbook.
  - Policy (South Carolina Medicaid Standard Appeal First Level)-001G refers to Kentucky Medicaid on the top of page 3 for definitions.
- The following documentation issues with appeal procedures are identified:

  - Policy (South Carolina Medicaid Standard Appeal First Level)-001G indicates the appeals process outlined includes dental services.
  - Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B use the terms "notice of action" and "adverse determination notice" instead of the terms "adverse benefit determination notice" or "notice of adverse benefit determination." Refer to the *SCDHHS Contract, Section 9.1.5*.
  - oPolicy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B do not include the requirement that the plan will provide assistance with completing appeals forms or procedures, as required by the *SCDHHS Contract, Section 9.1.4.2*.
  - Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter do not address the requirements to provide an opportunity for members to present evidence related to their appeal, inform members of the limited time available to present evidence prior to the appeal resolution, and to inform members they can examine their appeal case file before and during the appeal process. Refer to the *SCDHHS Contract, Sections 9.1.4.4.2* and *9.1.4.4.3*.).

- Policy Medicaid Standard Appeal First Level)-001G does not include the requirement that notice of appeal resolution must be provided within 30 days of receipt of the appeal.
- Policy (Medicaid Expedited Appeal First Level)-001B does not include the requirement members will be informed they may file a grievance if their request for an expedited appeal is denied.
- Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B do not include information that members have 120 days from the date on the appeal resolution notice to request a State Fair Hearing.
- CCME could not identify Humana's process for ensuring Targeted Care Management services are provided. The Care Management Program Description does not define or describe Targeted Care Management or identify the population to receive these services, according to requirements in the *SCDHHS Contract, Section 4.2.27.*
- A Transition Coordinator has not been designated. Humana staff explained recruitment efforts are in progress to fill that role.
- The process or plan for how Humana will detect and monitor over and underutilization was incomplete.

Quality Improvement Plans

- Update the information in the Member Handbook and Provider Manual regarding the requirements noted in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4*. Develop a process for how Humana will handle hysterectomies, sterilizations and abortions that meets the state and federal requirements.
- Revise Policy (South Carolina Medicaid Standard Appeal First Level)-001G to remove the reference to dental appeals.
- Edit the Key Words and Appeals sections of the Member Handbook to correctly define the term "appeal." Refer to the *SCDHHS Contract, Section 9.1 (a).*
- Include a definition and description of the term "adverse benefit determination" in the Member Handbook. Refer to the *SCDHHS Contract, Section 9.1 (b).*
- Remove the reference to Kentucky Medicaid from Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.
- Edit Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B to include the terms "adverse benefit determination notice" or "notice of adverse benefit determination" and include the requirement that Humana will provide assistance with appeals procedures.
- Edit Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter to include requirements that Humana will provide an opportunity for members to present evidence related to their appeal, inform them of the limited time available to do so, and inform members they can examine their appeal case file according to requirements in the *SCDHHS Contract, Sections 9.1.4.4.2* and *9.1.4.4.3*.
- include the requirement that the notice of the appeal resolution the must be provided within 30 days of receipt of the appeal.
- Edit Policy Medicaid Expedited Appeal First Level)-001B, to include the requirement that Humana will inform the member of their right to file a grievance if the member disagrees with the denial of expedited processing of an appeal request.
- Define and describe, in a program description or other document, Humana's process for ensuring Targeted Care Management services are provided to the population specified in the *SCDHHS Contract, Section 4.2.27.*
- Develop a plan or process for how Humana will monitor over and underutilization.

Recommendations

- Edit the Member Handbook and Provider Manual to include information that service authorization decisions can be extended by 14 days when requested by the member or the plan, according to documentation in Policy UM-Timeliness of UM Determinations)-005 and requirements in the *SCDHHS Contract, Sections 8.6.1.3* and *8.6.2.3*.
- Include in a document, such as the UM Program Description, QI Program Description, and SC Committee Charters, that participating network providers with various medical disciplines are included as members of the committee(s) responsible for overseeing UM activities.
- Include a description for post stabilization services in the UM Program Description.
- Edit Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B to include that members have 120 days from the date on the appeal resolution notice to request a State Fair Hearing, according to requirements in the *SCDHHS Contract, Section 9.1.6.3.1.1*.
- Continue recruitment efforts for a Transition Coordinator to ensure compliance with the *SCDHHS Contract, Section 5.6.2*.

F. Delegation

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

CCME's review of Delegation included the submitted Delegate List, delegation agreements, and delegation monitoring materials.

Humana has delegation agreements with the entities displayed in *Table 7: Delegated Entities and Services*.

Table 7: Delegated Entities and Services

Delegated Entities	Delegated Services
•National Medical Review (NMR) •FOCUS Health, Inc.	Utilization Review
•AnMed Health •Carolina Family Health Inc/MUSC Physicians PCP •St Francis Physician Services/Bon Secours Medical Group •United Physicians, Inc.	Credentialing
•Superior Vision Benefit Manager, Inc.	Vision Benefit Management
•Infomedia Group, Inc. dba Carenet Healthcare Services	24/7 Nurse Advice Line

As noted in the Subcontractor Monitoring and Oversight Plan and in Policy (Delegation)-001, Humana retains accountability for each delegated service and monitors the performance of delegated entities. A pre-delegation review is conducted to assess each entity's program, associated policies and procedures, staffing capabilities, and performance record prior to the entity performing the delegated activity. Humana will conduct annual oversight monitoring for each delegated entity to determine whether the delegated activities are being carried out as required.

The Delegation Policy attached to Policy (Delegation)-001 defines processes for delegation approval and states the Delegated Services Addendum and Delegation Attachment must: be executed for each delegated function; describe the activities and the responsibilities of Humana and the Delegated Entity; require at least semiannual reporting; describe how Humana evaluates the delegated entity's performance; and describe the remedies available if the delegate does not fulfill its obligations. However, the policy does not fully address requirements for sub-delegation. It fails to include that SCDHHS must receive prior notification of any further delegation by a subcontractor. Also, the policy addresses checking the OIG and SAM during the pre-delegation assessment but does not address the queries on an ongoing basis as required by the *SCDHHS Contract, Section 2.5.13*.

As indicated in *Figure 7, Delegation Findings*, 50% of the standards in the Delegation section were scored as "Met."

Figure 7: Delegation Findings

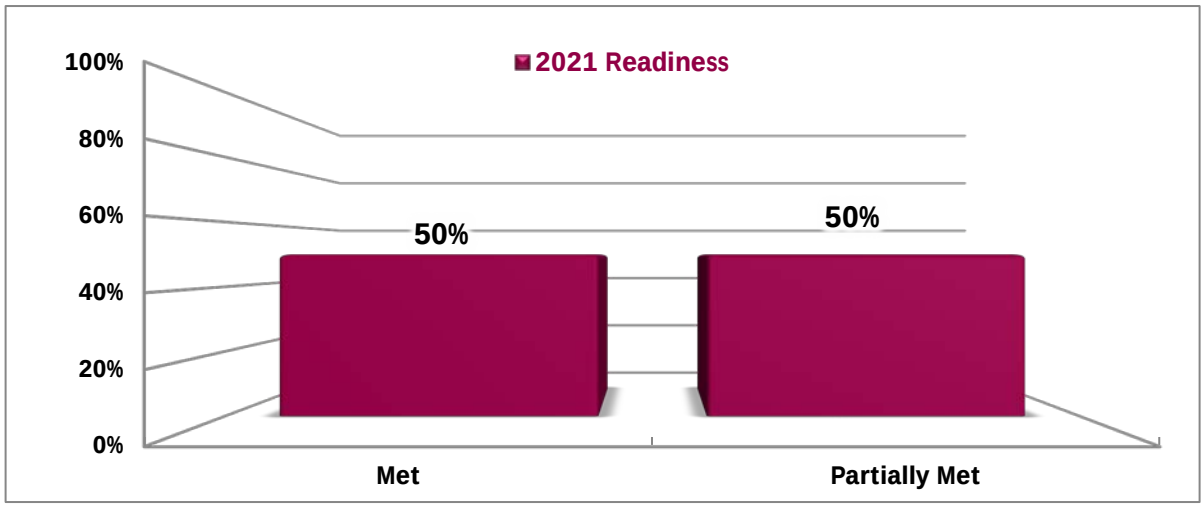


Table 8: Delegation Standards Needing Improvements

SECTION	STANDARD	2021 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

The standards reflected in the table are only the standards that received a less than Met score.

Weaknesses

- Issues identified in the Delegation Policy attached to Policy (Delegation)-001 include:
  - Requirements for sub delegation under multiple headings in the policy do not address the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor.
  - The policy addresses checking the OIG and SAM during the pre-delegation assessment but does not address the queries on an ongoing basis. Refer to the *SCDHHS Contract, Section 2.5.13*.

Quality Improvement Plan

- Revise the Delegation Policy attached to Policy (Delegation)-001 to include the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor and to include requirements for checking the OIG and SAM on an ongoing basis.

ATTACHMENTS

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: Tabular Spreadsheet

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

The Carolinas Center *for* Medical Excellence
1320 Main Street, Suite 300, Columbia, SC 29201 • 803.212.7500 • 800.922.3089 • www.thecarolinascenter.org

February 1, 2021

Natalia Aresu
Regional President
Humana
2160 Harbison Blvd
Columbia, SC 29212

Dear Ms. Aresu:

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

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services. Due to COVID-19 the two day onsite will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **April 6, 2021 and April 7, 2021.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **February 15, 2021.**

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

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review (Readiness Review)

MATERIALS REQUESTED FOR DESK REVIEW

1. A description of the managed care organization (MCO), including any lines of business in addition to South Carolina Medicaid managed care.

2. 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.

3. Organizational chart of all staff members including names of individuals in each position, and any current vacancies. If this is a corporate organizational chart, please identify those persons who will have responsibility for overseeing South Carolina Medicaid activities and where they will be located.

4. Current staffing levels and changes projected for increasing enrollment.

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

6. A complete list of network providers for the SC Medicaid 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

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

8. Service availability and accessibility standards and reports of any assessments (if conducted) made of provider and/or internal MCO compliance with these standards.

9. A proposed provider list/directory as supplied to members.

10. A copy of the current Compliance plan and the organizational 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.

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

12. The Quality Improvement work plan for 2021 or a sample of the proposed workplan.

13. Planned format for documenting all Performance Improvement Projects (PIPs). 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, barriers to improvement, results, etc.…).

14. Planned methodology for collecting and reporting performance and quality measure data.

15. A committee matrix for all planned committees. For each committee, please include the following:
    a. A copy of the committee charter. Include the committee's responsibilities, meeting frequency, and the required voting quorum.
    b. Membership list and indicate which members are voting members. Include the professional specialty of any non-staff members.
    c. The planned format for recording meeting minutes.

16. Minutes for any committee meeting(s) that has taken 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.

17. Plans for data collection for the purposes of monitoring the utilization (over and under) of heath care services.

18. A copy of staff handbooks/training manuals, orientation and educational materials. Please include training schedules and/or workplans.

19. Copies of scripts to be used by Member Services Representatives and/or Call Center personnel.

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

21. All information to be supplied as orientation to new members.

22. Planned methodology for assessing member satisfaction.

23. Samples and/or descriptions of planned member educational materials and activities, including any newsletters or mass mailings.

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

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

26. 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 services and covered benefits is assessed.

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

28. Provider orientation/training/education materials or programs.

29. A copy of the provider handbook or manual.

30. A sample provider contract and process/documentation of Hospital Admitting Privileges Requirement.

31. Provide electronic copies of the following Credentialing files:
    a. Ten PCP's (Include two NP's acting as PCP's, if applicable);
    b. Two OB/GYNs;
    c. Two specialists;
    d. Two behavioral health providers;
    e. Two network hospitals; and
    f. One file for each additional type of facility in the network.

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 polices with respect to email and PHI.
    i. A copy of the Information Security Plan & Security Risk Assessment.

33. A listing of all delegated activities, the name of the subcontractor(s), methods for oversight of the delegated activities by the MCO, and any reports of activities submitted by the subcontractor to the MCO.

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 CCME's discretion.

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2021

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Copy of policy CMS CMU Policy date January 1, 2013 referenced in policy (Quality Assessment and Monitoring Activities)-014.
3. A policy that addresses Humana's process for monitoring and facilitating continuity and coordination of care between the PCP and other entities.
4. A copy of the desk top procedure and/or standard operating procedure for handling service authorizations.
5. Copy of an EPSDT program description, policy or tool kit.
6. The Pharmacy Lock-in Program letter template.
7. A policy or other document for Specialty Pharmacy Medications.
8. A policy or document for the emergency supply of medications.
9. A copy of the SC TANF CHIP Specific Core Benefit policy. This was references in the HM4200 - 07012021 - Policy(UM- Core Benefits and Services)-007.

C. Attachment 3: Tabular Spreadsheet

CCME MCO Readiness Review Data Collection Tool

Plan Name:	Humana Healthy Horizons
Collection Date:	2021

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.		X				Humana has in place written policies and procedures that state its commitment to demonstrate compliance with applicable federal and state standards. Many of the policies contained wording directly from the *SCDHHS Contract* and did not specifically indicate Humana's process for meeting the requirements. Many of the policies contained information related to Medicare or to other lines of business and were not specific to South Carolina. Policies are not consistent in the manner in which they are titled and formatted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Complete a comprehensive review of policies and procedures and add Humana's processes to accurately reflect steps currently in place or that need to be in place to demonstrate Contract compliance.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					The South Carolina Market Plan President and CEO is Natalia Aresu.
1.2 Chief Financial Officer (CFO);	X					Bill Stephens serves as Humana's Chief Financial Officer.
1.3 * Contract Account Manager;	X					Humana is currently recruiting for this position. The CEO will take on these responsibilities until membership reaches 90 thousand.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Sarah Porter is the Billing and Encounter Manager.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					These positions will be filled by May 2021. The claims processing staff ratio will be 1:20,000.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Lead Utilization Manager is Cali Brou for Medicaid Service Operations.
1.5.1 Pharmacy Director,	X					Melissa Perraut is the Pharmacy Director residing in KY.
1.5.2 Utilization Review Staff,			X			It was reported during the onsite discussion that Humana was currently recruiting UM staff. The expected ratio will be one nurse per 15,000 members. *Quality Improvement Plan: Continue the recruitment efforts for clinical staff responsible for conducting utilization management functions.*
1.5.3 *Case Management Staff,			X			Humana is currently recruiting Case Management staff for SC. The Case Manager staffing ration will be one case manager per 5,000 members. *Quality Improvement Plan: Develop a plan to ensure staff are hired in South Carolina and orientation completed before members are enrolled.*
1.6 *Quality Improvement (Coordinator, Manager, Director);			X			The Quality Improvement Manager position is currently a vacant position. Humana's Medical Director will assume these responsibilities until the Plan reaches 90k members. However, currently an offer is pending for the Medical Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Develop a plan to hire a Medical Director to cover the Quality Improvement activities until a SC Quality Improvement Manager can be hired.
1.6.1 Quality Assessment and Performance Improvement Staff,			X			It was reported during the onsite discussion that QM staff are being recruited. The staffing ratio for the QM staff is expected at 1:45,000. *Quality Improvement Plan: Develop a recruitment plan to ensure staff are in-place to meet the expected staffing ratio.*
1.7 *Provider Services Manager;	X					Cynthia Forcade is the Provider Services Manager.
1.7.1 *Provider Services Staff,	X					Humana reported one Provider Services staff member has been hired in SC and will start on 4/19. An additional offer is pending.
1.8 *Member Services Manager;			X			Joe Piemonte is the Member Services Manager located in Florida. However, this position is required to be in South Carolina. *Quality Improvement Plan: Recruit a Member Services Manager that will be located in SC.*
1.8.1 Member Services Staff,	X					The on-site discussion indicated that Shared Services personnel would be utilized to support the Member Services department in South Carolina.
1.9 *Medical Director;			X			It was reported during the onsite discussion that Humana is currently recruiting, with an offer pending for a Medical Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Develop a plan to ensure this position is filled before members are enrolled.
1.10 *Compliance Officer;	X					Paula Burlison is the Compliance Officer located in SC.
1.10.1 Program Integrity Coordinator;	X					The Program Integrity Coordinator will be Pam Healy.
1.10.2 Compliance /Program Integrity Staff;	X					Staff employed for this team per the onsite discussion will support the local Plan by Shared Services.
1.11 * Interagency Liaison;	X					Kimberly McElroy is the Interagency Liaison for South Carolina Market.
1.12 Legal Staff;	X					Andrew Murr is identified as legal for Humana Shared Services.
1.13 Board Certified Psychiatrist or Psychologist;			X			It was reported during the onsite discussion that this position is not currently filled, recruitment is underway. *Quality Improvement Plan: Develop a plan to ensure this position is filled before members are enrolled.*
1.14 Post-payment Review Staff.	X					The Post Payment staff are expected to start in May 2021.
2. Operational relationships of MCO staff are clearly delineated.	X					The organizational chart clearly delineates operational relationships of MCO staff and lines of authority for South Carolina Market, Shared Services, and Medicaid Services roles.
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO processes provider claims in an accurate and timely fashion.	X					Humana's ISCA documentation states that the MCO complies with contractual timeframes regarding timeliness of claims and encounter processing. Humana also noted that its internal standard for claims processing is payment of 90% of all clean claims within 30 days of receipt and payment of 99% of clean claims within 90 days of receipt.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Humana's documentation describes systems capable of handling HIPAA compliant electronic transactions. Supporting data was provided that reported 97% of all claims submitted to the MCO were done so electronically.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Humana's documentation indicates it can meet the requirements of updating the eligibility/enrollment databases and handling 834 transactions. The MCO's documentation detailed how 834 files are processed, the demographic fields that are used, how members are uniquely identified. Humana uses Name, DOB, Address, SSN and Medicaid ID to determine if an enrollee record is duplicate. If an enrollee record is a duplicate the MCO combines the two profiles so there is only one.
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					Humana leverages a 3rd party to process and create HEDIS reports. Humana's HEDIS partner performs monthly integrity checks to ensure the validity of its HEDIS data. Additionally, the reporting results are audited to ensure that processing logic is interpreting data correctly.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Humana submitted a number of policy and procedural documents for the ISCA. Those documents indicate a focus on electronic and physical security controls. Each of the policy and procedural documents have recent revision timestamps which indicates documentation is regularly reviewed and updated. Finally, Humana should be commended for having a data classification policy. Humana's data classification policy details the MCO's staff and process requirements for labeling and handling the various types of data handled.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Humana provided documentation detailing its system and information security and access management. The documentation includes policies requiring staff to practice the principal of least privilege and for systems to enforce access restrictions based on user role
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Humana has a comprehensive disaster recovery (DR) plan that is reviewed and updated regularly. The DR plan is tested annually with a mix of tabletop and live failover testing. The most recent DR test was successfully completed and validated in August 2020.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Humana Corporate Compliance Plan, as described in Policy (SC Compliance Plan)-00, emphasizes the goal of creating a workplace environment in which ethics are integral in the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						day-to-day operations with regards to ethical conduct, enabling the effectively identification of and ways to address foreseeable risks, promptly respond to new legal or regulatory exposures, and achieve business objectives in an appropriate manner.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					Policy (Compliance Policy for Contracted Healthcare Providers and Third Parties)-004A outlines the purpose of the policy which is to aid Humana-contracted physicians, healthcare providers, and third parties in fully understanding Humana's strong organizational commitment to conducting business ethically, with integrity, and in compliance with applicable laws, regulations, and requirements.
2.1 Standards of conduct;						Humana's Every Day document outlines the expectation of conduct as it applies to employees, contracted health care providers, and business partners. It defines ethical violations to include those of violations of law, policies, dishonesty, unethical behavior, conflicts of interest, fraud, waste, and abuse, questionable accounting and internal controls, criminal conduct, suspicious activity etc. Reporting information to include anonymity, is provided for internal and external options. Examples and outcomes are described in this and other required trainings.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The Compliance Committee is Chaired by the CCO with members who have decision-making authority and responsibility throughout the organization. The Compliance Committee meets on a quarterly basis, and more frequently as necessary. It monitors significant issues, metrics, training, and adherence to compliance policies, ensuring that the compliance program is effective. Reports to the Committee include those from the Medicare-Medicaid Compliance Officer on behalf of the Medicare and Medicaid Compliance Committee and the Commercial/Specialty Compliance Officer on behalf of the Federal Health Insurance Marketplace to review compliance program activities.
2.5 Compliance training and education;						The Humana Compliance Committee is responsible for providing training and oversight to the Medicare and Medicaid programs. Trainings include fraud, waste, and abuse, privacy and ethics programs, ethics and compliance, Operational Risk Assessment, and internal and external audits. Employees of entities acquired by Humana are required to complete training within 30 days of hire or start

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						date and 60 days of acquisition close date and annually thereafter.
2.6 Lines of communication;						Lines of communication are clearly outlined between the Compliance Officer and the employees, contractors and subcontractors, and providers in the Compliance Organizational Chart, the Corporate Compliance Plan, the Ethics Every Day document, and the Member Handbook.
2.7 Enforcement and accessibility;						To support enforcement of disciplinary action, Humana has developed policies, processes, and/or practices that provide for timely, consistent, and effective enforcement of the standards when noncompliance or unethical behavior is determined.
2.8 Internal monitoring and auditing;						The GRC Working Groups provide oversight to the monitoring and auditing activities within Humana. This includes internal monitoring and audits, risk-based assessments and, as appropriate, external monitoring and auditing to evaluate Humana's compliance with state and federal requirements and the overall effectiveness of the compliance program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.9 Response to offenses and corrective action;						When identified by any Humana associate, issues are forwarded to the Agent Investigation Unit (AIU) for review. The AIU has developed policies and procedures to conduct the investigation and report the findings to the appropriate department for corrective action as needed.
2.10 Data mining, analysis, and reporting;						The SIU Anti-Fraud Plan details the processes taken by Humana's SIU for the detection, investigation, and prevention of suspected fraud and abuse for all lines of business, Medicaid, Commercial, and the Federal Health Insurance Marketplace. SIU receives referrals from various sources, including but not limited to hotline calls, data-mining results, fraud detection software, and government agencies.
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					Policies and procedures are in place to identify, prevent, and report suspected fraud, waste, and abuse. However, a supplemental document entitled South Carolina Addendum to Humana Anti-Fraud Plan does not provide clear processes as indicated in the Corporate Compliance Plan. *Recommendation: Review and revise the South Carolina Addendum to Humana Anti-Fraud Plan*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to reflect congruent information outlined in the Corporate Compliance Plan specific to fraud, waste, and abuse processes and procedures.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The SIU Anti-Fraud Plan details Humana's processes for detection, investigation, and prevention of suspected fraud and abuse for all lines of business. SIU receives referrals from hotline calls, data-mining results, fraud detection software, and government agencies. These referrals are investigated by the SIU to determine if the suspected fraud and abuse activities have occurred. If an allegation is substantiated, SIU may refer the provider to the appropriate government agencies, law enforcement, recommend actions and/or termination from Humana's network. SIU also provides recommendations for process improvements to proactively address potential fraud risks identified in Humana's business practices.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The Corporate Compliance Plan describes the process of the Provider Payment Integrity (PPI) department, which utilizes complex data analytics including outlier analysis, trending, and link analysis to identify potential fraud, waste, and abuse. Humana's PPI conducts pre-payment and post-payment audits to identify potential overpayments for referral to the appropriate department for review and action.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy (Pharmacy Lock-n Program)-003 indicates that the Statewide Pharmacy Lock-In Program (SPLIP) addresses issues of patient safety, improper or excessive utilization of medications, and potential abuse when members use multiple pharmacies and/or prescribers. The Overutilization Review and Monitoring department will review the quarterly report received by the South Carolina Department of Health and Human Services.
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					Policy (General Contractual Conditions Confidentiality Policy)-022 applies to all Humana associates, as well as all subcontractors who functions for the Plan. When privileged or confidential information is requested for release to a third-party, it will not be provided without consent of the Department or the member or potential member.

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Policy (CORE Credentialing and Recredentialing (21st ed))-001A is the Humana corporate Credentialing and Recredentialing policy and defines overall processes for initial credentialing and recredentialing of independent practitioners and organizational providers. The policy addresses: •Types of practitioners who require credentialing •Verification sources for provider information •Practitioner educational and training requirements •Decision-making criteria and processes for credentialing and recredentialing •Requirements for confidentiality and non-discrimination in the credentialing process •Practitioner rights related to credentialing The South Carolina Healthy Connections CORE Credentialing & Recredentialing policy (Policy (CORE Credentialing and Recredentialing)-001) acts as a supplement to the corporate policy and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						includes requirements specific to the SC Medicaid product. Policy (CORE Credentialing and Recredentialing (21st ed))-001A, page 9, states, "Upon receipt of a complete credentialing application, the credentialing process should be completed within 30 days or as required by state or federal regulations." Policy (CORE Credentialing and Recredentialing)-001 includes the *SCDHHS Contract, Section 2.8.2.4.2* requirement that credentialing applications be processes within 60 calendar days in its "Contract Reference" section, but the policy does not include the timeframe for processing credentialing applications in the "Policy and Procedures" section. Onsite discussion revealed Humana will follow the 30 calendar-day timeframe for processing credentialing applications. *Recommendation: Because credentialing application processing for SC providers will follow the corporate timeframe of 30 calendar days, revise the "Policies and Procedures" section of Policy (CORE Credentialing and Recredentialing)-001 to indicate a 30-day timeframe will be followed for SC provider credentialing.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME could not identify a policy or other document that addressed requirements from the *SCDHHS Contract, Section 11.12.11.7* to report to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery. Onsite discussion revealed Humana takes action within 48 hours to terminate the provider and immediately notifies SCDHHS. *Quality Improvement Plan: Revise an appropriate policy to define the process Humana will follow for report to SCDHHS any network providers that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other federal program immediately upon discovery.*
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			Humana does not have a local Credentialing Committee. Instead, Humana's Corporate Credentials Committee reviews and makes the final credentialing determination for each market/plan. Humana confirmed during the onsite that there is no representation from South Carolina on this corporate committee. However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8* requires the following:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•"Each MCO will maintain a Credentialing Committee." •"The MCO's Medical Director shall have overall responsibility for the committee's activities." •"The committee shall have a broad representation from all disciplines (including mid-level practitioners) and reflect a peer review process." *Quality Improvement Plan: Establish a local (plan level) Credentialing Committee to make credentialing determinations for the South Carolina Medicaid provider network. Ensure the MCO Medical Director oversees and has overall responsibility for the committee's activities. Ensure the committee includes network provider representation from various specialties, including mid-level practitioners. A committee charter should be developed to specify the committee's roles and responsibilities, membership, meeting frequency, quorum, attendance requirements, etc. The corporate Credentials Committee may make initial credentialing determinations, but the ultimate approval of all South Carolina Medicaid network providers is the responsibility of the plan-level Credentialing Committee.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.		X				Policy (CORE Credentialing and Recredentialing)-001 states, "Humana shall credential and recredential contracted providers in accordance with NCQA credentialing and recredentialing standards as outlined in the Corporate Credentialing and Recredentialing Policy and the South Carolina's Department of Health and Human Services (SCDHHS) contract." NCQA HP Standards and Guidelines, CR 1: Credentialing Policies, Element A: Practitioner Credentialing Guidelines, Factor 8: Notification of decisions requires the health plan to notify applicants of initial credentialing decisions and recredentialing denials no later than 60 calendar days from the Credentialing Committee's decision. For all independent practitioner credentialing files reviewed, the date on the approval notification letter was prior to the date of the Credentialing Committee's decision to approve the provider. Humana stated during onsite discussion that once the Medical Director approves Category I (or "clean") credentialing files, the approval letter is sent to the practitioner. CCME requested on two occasions the dates of Medical Director approval for the reviewed files. This information was not provided.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure independent practitioner credentialing files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Of two nurse practitioner files submitted for review, only one included the formal collaborative agreement between the nurse practitioner and the supervising physician. Humana staff responded to this issue with the following statements: •"Provider is not staffed at a nurse practitioner only facility." •"Provider South Carolina Nurse Practitioner license says Supervised by Daniel Robert Conner (MDO)." •"Provider South Carolina Nurse Practitioner license was verified 12/16/2020." However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8* "Requirements for the Utilization of Nurse Practitioners (NPs) as Providers of Health Care Services" states MCOs must confirm the nurse practitioner's ability to provide the allowed services as evidenced by written protocols.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician. Additional issues are addressed in the individual standards below.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.6 Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					For some credentialing files, the Provider Credentialing Profile checklist states "acknowledged" for the NPDB verification type. Humana staff stated during onsite discussion that this is an indication that the NPDB was queried with no reports returned. The use of the term "acknowledged" is not defined in the "Verification Type Code" listing at the bottom of the checklist. *Recommendation: Revise the "Verification Type Code" listing on the Provider Credentialing Profile checklist to include the term "acknowledged" and what that means in relation to the NPDB query.*
3.1.8 No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;			X			For 12 provider credentialing files, CCME did not identify evidence of verification of CLIA when the provider indicated laboratory services are conducted in their offices. Humana responded that "CLIA certification is issued per facility site location, rather than issuing to an individual practitioner. Verification of CLIA for individual practitioners is not an NCQA standard or

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirement. It is Humana's practice to verify CLIA when credentialing per facility site location as part of the credentialing and recredentialing process for facilities." However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8 states,* "An MCO is responsible for insuring all persons, whether they are employees, agents, Subcontractors, or anyone acting on behalf of the MCO, are properly licensed under applicable South Carolina laws and/or regulations… All applicable healthcare professionals and healthcare facilities used in the delivery of Benefits by or through the MCO shall be currently licensed to practice or operate in South Carolina as required and defined by the standards listed below." This includes "All Providers billing laboratory Procedures must have a Clinical Laboratory Improvement Amendment (CLIA) certificate." For the Medicaid Managed Care Program, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations* defines the term "provider" as "any individual, group, Physicians (including but not limited to Primary Care Providers and Specialists) or entity (such as but not limited to Hospitals, Ancillary Providers, Clinics, Outpatient Centers (free

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standing or owned) and Laboratories) that is engaged in the delivery of health care services and is legally authorized to do so by the state in which it delivers services." *Quality Improvement Plan: Ensure all provider credentialing files contain evidence of verification of the CLIA when the provider application indicates laboratory services are conducted in the provider's office/location.*
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					Recredentialing processes are documented in Policy (CORE Credentialing and Recredentialing (21st ed))-001A and (Policy (CORE Credentialing and Recredentialing)-001.
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.3 Review of practitioner profiling activities.	X					Policy (CORE Credentialing and Recredentialing (21st ed))-001A states performance indicators are considered during recredentialing. Practitioners' performance records include activities/findings collected through Humana's quality improvement programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys and other plan activities.
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy (CORE Credentialing and Recredentialing (21st ed))-001A states Humana may terminate a provider's network participation for reasons relating to quality that adversely affect, or could adversely affect, a patient's health or welfare. Policy NNO 703-016-18, Provider Terminations and Member Notifications, describes the provider termination and member notification process.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy (SC Medicaid Provider Terminations and Member Notifications)-005 defines processes for notifying members and SCDHHS of provider terminations and significant network changes.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.		X				Policy (CORE Credentialing and Recredentialing (21st ed))-001A includes credentialing and recredentialing requirements specific to organizational providers. Review of 14 credentialing files for organizational providers revealed the following issues: •A total of 13 of 14 organization provider credentialing files did not contain an attestation that the information submitted was accurate. Humana responded that applications are not required from organizational providers at the time of recredentialing. •None of the files included verification of liability coverage. Humana responded that verification of liability coverage for organizational providers is not required by NCQA, and although Humana requires organizational providers to have appropriate liability coverage, this is not verified at the time of credentialing. •As noted in standard 3 above, the credentialing determination notification letters for all the reviewed organizational providers were dated prior to the credentialing determination date supplied by Humana.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The CLIA verification for two hospitals were conducted after the credentialing determination date supplied by Humana. One was 11 months after the decision date, and the other was 5 months after the decision date. Humana responded that this issue had already been identified and resulted in retraining of staff. and publication of updated staff guidance documentation. *Quality Improvement Plan: For organizational provider credentialing files, ensure:* *•the files include a signed statement that the information submitted is accurate to the best of the signee's knowledge.* *•the files include verification of liability insurance required by Humana.* *•independent practitioner credentialing files reflect the date of Medical Director approval of Category I files and that files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.* *•CLIA verification is conducted prior to the credentialing determination.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Policy (CORE Credentialing and Recredentialing (21st ed))-001A defines sources for monitoring sanctions and licensure restrictions and states

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Humana monitors practitioner sanctions monthly between recredentialing cycles. Policy (CORE Sanctions Policy)-002 describes the sanction monitoring process. Practitioners identified as having contracts for Medicaid services will have action taken no later than 48 hours (excluding non-business days) of the sanction discovery.
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 has in place a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					Policy (SC Medicaid Network Availability and Access) 004 defines PCP access requirements that comply with SCDHHS requirements. PCPs are defined in the policy as Family Practice, Pediatrics, General Practice, Internal Medicine, FQHCs, and RHCs. The Humana Healthy Horizons in South Carolina Provider Support Plan (Network Development Plan) includes the Medicaid Network Adequacy Report (with data as of November 10, 2020). The

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						compliance rate for Pediatrics was 95.7% and for other primary care providers was 100%.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy (SC Medicaid Network Availability and Access) 004 states Humana must have Status 1 providers in its network. The Network Development Plan includes the Medicaid Network Adequacy Report (with data as of November 10, 2020) and includes all compliance rates for required Status 1 specialists and hospitals. CCME noted the compliance rates for several specialties were below the 90% benchmark: •Gastroenterology 89.1% •Hematology and Oncology 71.7% •Neurology 84.8% •Occupational Therapy 76.1% •Psychologist 84.8% •Urology 82.6% Humana staff noted that recruiting and contracting efforts are underway to increase the number of network providers of these specialties.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy (SC Medicaid Network Availability and Access)-004 states geo access analytics will be conducted monthly and on an ad hoc basis if there is a significant network change from a provider termination. Monthly adequacy reports

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						will be run to identify gaps in the network, and if noted, the SC Contracting team will review gaps, research how gaps could be closed, and attempt to contract with potential providers for contract. Network availability will also be monitored using member satisfaction survey results, analysis of complaints/grievances, requests for out of network agreements, and Mystery Shopper Survey results. Neither Policy (SC Medicaid Network Availability and Access)-004 nor the Network Development Plan address Humana's plan to ensure members have a choice of at least two contracted specialists who are accepting new patients within their geographic area. This was discussed with Humana staff, and they responded that this requirement is built into the network adequacy algorithms used in geo access reporting and other network adequacy measurement. *Recommendation: Revise either Policy (SC Medicaid Network Availability and Access) 004 or the Network Development Plan to address Humana's plan to ensure members have a choice of at least two contracted specialists who are accepting new patients within the members' geographic area.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 draft QI Program Description addresses Culturally and Linguistically Appropriate Services (CLAS). It states: "Humana is sensitive to the barriers encountered by many of its members based on their race, ethnicity, socioeconomic status, education, language and physical attributes. Humana continues to develop policies and initiatives to eliminate those inequalities, health disparities, and barriers." According to the program description, activities include: •Collecting and validating data used to identify the ethnicity and racial make-up of membership. •Annual employee education about cultural sensitivity and competency. •Ongoing monitoring of tools or processes to provide member information in a format viable for them, including Spanish translation of documents, telecommunications device for the deaf (TDD) services, translator services (including the providers office if indicated), and braille translations of key documents. •Distribution of cultural competence resources and training to providers. •The Corporate Bold Gold Initiative that focuses on the impact of food insecurity, social isolation and captures the impact on healthy days in those communities.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The draft Provider Manual provides an overview of Cultural Competency, including references to applicable state and federal laws and regulations. Page 60 of the Provider Manual states Humana's Cultural Competency Plan can be viewed at on the Humana.com website. However, the hyperlink in the Provider Manual takes the user to a page with a heading of "Language assistance and diversity" that only covered topics related to interpreters, translation services, etc. The Humana Cultural Competency Plan was not located on this page or able to be located elsewhere on the website by using the search functionality. Of note, the webpage did link the user to the Cultural Competency Training 2021 document that includes topics of culture and cultural competence, clear communication, various subcultures and populations, and strategies for working with seniors and people with disabilities. *Recommendation: Ensure the hyperlink to the Humana Cultural Competency Plan listed in the Provider Manual is correct and that the Humana Cultural Competency Plan is easily located on the website.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					Humana's Network Development Plan indicates Humana will establish a network that meets geographic access standards for Status 1 providers. The plan is to have a PCP to member ratio of 1:2000. Humana's processes include a process to ensure network gaps are researched for closure and to monitor the network for future gaps to ensure members have access to covered services.
2. The MCO maintains a provider directory that includes all requirements outlined in the contract.		X				Humana staff were unsure whether a hard copy of the Provider Directory will be provided to new members. However, it will be available on the website. Policy (Member Handbook-Provider Directory-Enrollee Rights)–014 states members will be able to contact Member Services to request a copy of the Provider Directory. The draft Provider Directories submitted for review include required provider types and all required elements except completed cultural competency training, as required by the *SCDHHS Contract, Section 3.13.5.1.1*. When discussed during the onsite, Humana staff stated this is currently not included and were unable to verbalize a plan to include this in the future but stated they will work toward compliance with this requirement.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy (SC Medicaid Provider System Loading and Directory Change Requests)-006 states Humana's Provider Directories are updated nightly. The policy describes processes to ensure new providers will be loaded into the Provider Directory system within 60 calendar days and provider information in the print directory will be updated within 30 calendar days. *Quality Improvement Plan: Ensure the Provider Directory includes cultural competency training completed by providers, as required by the SCDHHS Contract, Section 3.13.5.1.1.*
3.Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Policy (SC Medicaid Network Availability and Access)-004 defines accessibility standards for network providers that comply with requirements in the *SCDHHS Contract*.
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					Policy (Provider Training)-001 describes Humana's processes for ensuring network providers will receive appropriate training on the program and procedures when becoming active in

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the network and ongoing as needed. According to the policy: •Provider Contracting Representatives will perform orientation and training for all provider types. •Orientation will be conducted within 30 days of a provider's contract effective date with ongoing visits as needed. •Representatives will assist providers with a variety of topics and provide reference materials and quality measures like performance gap reports and pharmacy data. •Provider relations will schedule four regional provider training sessions per year. •There will be monthly in-service visits to PCP offices to educate, monitor performance, & assist with resolving issues. •Ad hoc provider site meetings and webinars will be provided for any provider type when a need is identified. Additional provider education activities will include periodic provider newsletters, annual compliance training, updates to the Humana.com provider portal, ad hoc provider mailings, faxed or mailed notifications of policy and procedure changes, and reference materials on the website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						CCME noted items "p" and "s" in the list of provider training topics on page 2 of Policy (Provider Training)-001 is incomplete. Also, page 3 of the policy includes a reference to another state's Provider Manual. *Recommendation: Correct the issues noted on pages 2 and 3 of Policy (Provider Training)-001.*
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					
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					Plan (Provider Training)-009 states ongoing provider training will include a variety of topics including provider requirements, member care expectations, changes in policies and procedures, billing and issues resolution processes. Training is delivered through print communications (provider manual, newsletters, clinical and non-clinical educational materials), the website and Availity.com, in-person trainings (face to face, town hall meetings), and virtual trainings (webinars). The Pharmacy Education & Training Plan 2021 states pharmacies will receive ongoing education based on a variety of topics including provider requirements, drug coverage, utilization management and prior authorization, policies and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						general claims procedures, billing and issues resolution processes, and clinical programs. Training will be delivered through communications such as the pharmacy manual, bulletins, and clinical practice guidelines; the pharmacy provider website and secure pharmacist portal; and annual Medicaid and Cultural Competency Training.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy Clinical Practice Guidelines – Medical and Behavioral QM-001-17 describes processes for review of adopted guidelines. The Clinical Practice Guideline Committee, chaired by a designated Humana Medical Director, meets biannually to review Humana endorsed guidelines. The committee is comprised of Humana medical directors including representatives from Behavioral Health, various specialty areas, and external physicians. Committee recommendations are forwarded to the market plans for inclusion in the local market quality committees. The guidelines are ultimately reviewed and approved by the Humana Corporate Quality Improvement Committee (CQIC).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Per the South Carolina Humana Preventive Guidelines Narrative document, Humana adopts relevant, evidence based non-preventive acute and chronic medical, behavioral health, and preventive guidelines (for all age groups, including perinatal care) from recognized sources such as professional medical associations, voluntary health organizations and NIH Centers and Institutes.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					The guidelines are posted to Humana's website and are available to members, providers, and the public. Information about the guidelines is included in the Humana Provider Manual. The Provider Manual states preventive health guidelines are distributed to all new and existing providers through Provider Manual updates, provider newsletters, and the provider website. It further states providers can receive preventive health guidelines through the care management department or their Provider Relations representative. The Provider Manual informs that Humana will monitor provider implementation of the guidelines through claim, pharmacy, and utilization data. Areas identified for improvement are tracked and corrective actions are taken as needed.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					CCME's review of the submitted preventive guidelines and the guidelines listed on the Humana.com website did not include the AAP/Bright Futures guidelines or any guidelines for Well Child Care other than a few specific screenings for children from the Prevention TaskForce Preventive Care Recommendations. Per onsite discussion and the South Carolina Humana Preventive Guidelines Narrative document the Clinical Practice Guideline Committee will review a recommendation for Well Child Care Guidelines at specified intervals. Approved guidelines will be added to Humana's website no later than July 1, 2021. *Recommendation: Ensure Humana's approved preventive health guidelines include a guideline for Well Child Care screenings according to the American Academy of Pediatrics (AAP) periodicity schedule, as required by the SCDHHS Contract, Section 4.2.10.2. Ensure the guideline is included in Policy QM-001-17.*
3.2 Recommended childhood immunizations;	X					The CDC recommended childhood immunizations are included in the guidelines submitted for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review and included on the Humana.com website.
3.3 Pregnancy care;	X					Guidelines for Perinatal Care are included in the guidelines submitted for review and included on the Humana.com website.
3.4 Adult screening recommendations at specified intervals;	X					Guidelines submitted for review and on the Humana website include Prevention TaskForce Preventive Care Recommendations, Recommended Vaccines Schedule for Adults Aged 19 Years and Older _ CDC, and Well Woman Preventive Visits.
3.5 Elderly screening recommendations at specified intervals;	X					Guidelines submitted for review and on the Humana website include Prevention TaskForce Preventive Care Recommendations.
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral Health Services.	X					
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					Policy Clinical Practice Guidelines – Medical and Behavioral QM-001-17 describes processes for review and adoption of clinical practice guidelines.
2. The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers.	X					The guidelines are posted to Humana's website and are available to members, providers, and the public. Information about the guidelines is included in the Humana Provider Manual. The Provider Manual states clinical practice guidelines are distributed to all new and existing providers through Provider Manual updates, provider newsletters, and the provider website. It further states providers can receive clinical practice guidelines through the care management department or their Provider Relations representative. The Provider Manual informs that Humana will monitor provider implementation of the guidelines through claim, pharmacy, and utilization data. Areas identified for improvement are tracked and corrective actions are taken as needed.
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.		X				The Provider Manual and Policy (External Quality Review)-006 HUM-SC-QM-008-01 indicate that medical records must contain documentation of referrals and results of referrals, documentation of emergency and/or after hours encounters and follow-up, and consultation reports. Pages 44-45 of the QI Program Description states coordination of care for members is assessed between settings of care and in transitions of care from one provider to another. Data sources listed in the program description for this activity include medical record reviews, HEDIS measurements, CAHPS results, Case/Disease Management data, and grievance and complaint data. However, the process for monitoring coordination of care between providers could not be identified the program description or in a policy. *Quality Improvement Plan: Ensure Humana's process for monitoring coordination of care between providers is documented in a policy, including methods of monitoring and assessment, processes for addressing any identified deficiencies, etc. PCPs should be aware of care members receive elsewhere, such as emergency rooms, from specialists, etc.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians.	X					Standards for medical record documentation for providers are documented in the Provider Manual (noted twice, on pages 67-68 and 71-72). Standards for medical record documentation were also noted in Policy (External Quality Review) HUM-SC-QM-008-01; however, the purpose of the policy is to outline how Humana will participate in an annual external quality review.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Medical record documentation standards listed in the documents noted above are compliant with requirements found in the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 15.8*.
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					Page 38 of the QI Program Description states, "The Humana Health Benefit Plan of South Carolina conducts medical record audits when required by contract. These audits evaluate physician compliance with adopted medical record documentation guidelines." CCME could not identify a policy or other document that defines Humana's process for monitoring provider compliance with medical record documentation standards through periodic

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						medical record audits. However, after the onsite, Policy (Medical Record Review)-013 [HUM-SC-QM-006] was submitted to CCME. The policy addresses the medical record sampling methodology, review process, review elements, and follow-up activities.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					The Physician Participation Agreement (provider contract) includes language that the provider "shall maintain up-to-date health records at the site where medical services are provided for each Medicaid Managed Care Member for whom services are provided under this Contract. Each Medicaid Managed Care Member's record must be legible and maintained in detail consistent with good medical and professional practice that permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment. The Department's representatives or designees shall have immediate and complete access to all records pertaining to the health care services provided to the Medicaid Managed Care Member."

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					Policy (Member Rights)-028 describes Humana's process to guarantee member rights and responsibilities according to requirements in the *SCDHHS Contract, Section 3.16*. Primarily, members are informed of their rights and responsibilities from the Member Handbook, and they are communicated in various member materials. Policy (Member Handbook-Provider Directory-Enrollee Rights)-014 indicates Customer Care Specialists will refer to the Humana Member Handbook when members have questions about their rights. Discussions during the virtual onsite confirmed that member rights and responsibilities are reviewed during staff core trainings, and staff will refer to the Member Handbook for the complete listing of member right and responsibilities.
2. Member rights include, but are not limited to, the right:	X					Member rights are correctly listed in Policy (Member Rights)-028, the Member Handbook and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Provider Manual according to *SCDHHS Contract, Section 3.16*.
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that they be amended or corrected as specified in Federal regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Policy (MARKETING)-001 Marketing and Member Communication and Policy (Enrollee ID Card Requirements)-001 indicate members will be issued a Welcome Packet and an ID card within 14 days of Humana receiving enrollment data from SCDHHS. The Welcome Packet includes an introduction letter, a Plan Booklet providing an overview of benefits and services, member rights and responsibilities, an HRA form, consent for release of PHI and, a Care Management form. The Plan Booklet contains extensive information and instructions to orient new members such as information about accessing the MyHumana Member Portal, the Member Handbook, and Provider Directory. Discussions during the virtual onsite revealed members will receive welcome calls from a third-party vendor to follow up and provide additional welcome information. See specific comments in standards 1.1 – 1.22 regarding the deficiencies identified.
1.1 Benefits and services included and excluded in coverage;						The Member Handbook includes covered benefits and contractually required services, indicates benefit limitations, and lists services that are not

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						covered. It includes a table of added benefits provided by Humana at no cost to the enrollee. Policy (Enrollee Handbook)-001 and Policy (UM-Core Benefits and Services)-007 indicate Humana includes benefit information in the Member Handbook, in accordance with the *SCDHHS Contract, Section 3.13.2.5.9*.
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						Humana staff indicated the plan has waived copayments for all members of any age and for all covered benefits. However, documentation on pages 13 and 19 of Policy (UM- Core Benefits and Services)-007 indicates that copayments are allowed for members aged 19 and older. The Member Handbook (page 36) indicates there is a $3.40 co-payment for medicines in the PDL for members aged 19 and older, except for children under age 18, federally recognized Native Americans and pregnant women.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Edit the Member Handbook and Policy (UM- Core Benefits and Services)-007, to be consistent with Humana's policy regarding copayments.
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Services that require prior authorization are clearly listed throughout the Member Handbook and Provider Manual. Prior approval is not required for family planning services and emergency visits. Out-of-network providers are required to have an authorization from Humana.
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;						Emergency care, post-stabilization care, and urgent care are correctly defined in the Member Handbook. Members are informed that in addition to their PCP, the Nurse Advice Line is available 24 hours a day, seven days a week. The Member Handbook provides clear and specific information instructing members on the appropriate level of care for routine, urgent, or emergent healthcare needs.
1.7 Policies and procedures for accessing specialty care;						The Member Handbook informs members that they can visit specialists within the network without a referral and instructs them to access the online provider directory to select a provider for needed services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Members can visit any network pharmacy to obtain prescription medications. Additionally, members can use Humana's mail-order pharmacy to have prescription medications or approved over-the-counter medications delivered to their door at no cost to the member. The Member Handbook includes information about obtaining prescription medications from participating pharmacies and visiting the website for the current version of the Preferred Drug List (PDL). Members are instructed to talk with their PCP or call Enrollee Services for information on durable medical equipment, prosthetics, or orthotics.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						The Member Handbook states Humana will send letters to members within 15 days prior to the effective date of their PCP's termination. Documentation of Humana's process for notifying members of changes in benefits 30 days before the effective date was not found in the Member Handbook. During the onsite, Humana staff explained that members are informed in writing of significant changes to benefits 30 days in advance of the effective date. *Quality Improvement Plan: Include information in the Member Handbook that members will be*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						informed of benefit changes in writing 30 days before the effective date as required by the SCDHHS Contract, Section 3.13.
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;						The Member Handbook provides information about requirements for disenrollment, for cause and without cause, and instructs members to call South Carolina Healthy Connections Choices to speak with an enrollment counselor. Policy (Disenrollment Requests)-009, indicates a Customer Care Specialist will refer the member to, and provide the telephone number for, SCDHHS when members request disenrollment.
1.12 Procedures for filing grievances and appeals, including the right to request a Fair Hearing;						Information and instructions for filing grievances, appeals, and State Fair Hearings are noted in the Member Handbook. Please refer to the respective grievance and appeals section in this report for specific findings.
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for their care and of alternate languages spoken by the provider's office;						The Member Handbook instructs members to access the online Provider Directory, the Provider Finder Tool, from the website or contact Member Services for assistance or to request a paper copy. Policy (On-line Provider Finder Tool and Hardcopy Directories)-003 describes Humana's process for ensuring the online provider finder

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						tool and corresponding hardcopy directories include descriptions and information about network providers, such as name, gender, and practice specialty. Humana staff explained the Provider Finder Tool will also identify providers who offer TeleHealth services.
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;						Member right and responsibilities are listed throughout the Member Handbook and are compliant with requirements of the *SCDHHS Contract, Section 3.13.2.5.3. and 42 CFR §438.100.*
1.16 Description of the Medicaid card and the MCO's Medicaid Managed Care Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						Humana maintains a Member Services call center from 8 a.m. to 6 p.m. Monday through Friday. The Key Contact Information and the Enrollee Services sections of the Member Handbook include important phone numbers, hours of operation, the 24-Hour Nurse Advice Line, and a description of services provided. The TTY:711 relay is communicated in several member materials.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						The Member Handbook provides limited information on EPSDT preventive services and does not adequately educate members about the requirements for this service. It includes basic information explaining that EPSDT services are for members from birth to their 21st birthday and has a bulleted list of EPSDT exam components. Unlike the Provider Manual, the Member Handbook does not provide a detailed description or definition of EPSDT preventive services such as a description of preventive exam components, the recommended age-appropriate exam intervals, or references to the AAP and Bright Futures Periodicity Schedule. During the onsite Humana staff reported the AAP and Bright Futures Periodicity Schedule will be available on the website once it is up and running. *Quality Improvement Plan: Edit the Member Handbook to expound on EPSDT Preventive information by including definitions and description of required examinations and the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						recommended schedule for members to obtain age-appropriate services.
1.20 A description of Advance Directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						The Member Handbook provides information for Physician Orders for Scope of Treatment (POST) forms, Living Wills, Healthcare Power of Attorney, and Mental Health Treatment Directives. Members over 18 years of age can establish an advance directive and are instructed to contact a qualified legal professional for more information.
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					Humana staff explained an annual mailing will be conducted to notify members of their right to request a Member Handbook or Provider Directory. Other methods may include website and social media messages.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Members are informed in writing of changes in benefits and changes to the provider network.		X				Humana will notify members in writing within 15 days prior to the effective date of their PCP's termination as noted in Policy (SC Medicaid Provider Terminations and Member Notifications). There was no documentation provided regarding how Humana will notify members of changes in benefits. *Quality Improvement: Document in a policy the process for informing members in writing of changes in benefits as required by the SCDHHS Contract Section 3.13.*
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy (MARKETING)-001 describes and outlines the processes Humana uses to ensure member program materials are written in a clear and understandable manner and meet contractual requirements. Humana will provide written communications in specific languages when 5% of the population speaks a specific language, as described in Policy (Humana CSA Requesting Written Communications in Non-English)-002. Humana's threshold language is Spanish, and documents provided in English must be provided in Spanish as well. The Creative Development Team Reference Tool provides guidance to staff for processing member

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						communication materials according to requirements in the *SCDHHS Contract, Sections 3.14.6* and *3.15*. Discussions during the onsite confirmed member materials are written with a minimum 12-point font size and include required taglines written in 18-point size. Additionally, staff use the Flesch-Kincaid Index and/or Acrolinx editor to ensure materials are communicated at a fourth grade reading level.
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					Discussions during the onsite confirmed Humana's Member Services Call Center is in Kentucky, and policies and procedures are established to provide call center services. Policy (Toll Free Line)-021, the Standard Operating Procedure-Call Center Operations-Toll Free Line document, and the Standard Operating Procedure- Call Center Operations- SC Medicaid Call Performance Metrics and Standards Call Center document, describe Humana's approach for providing 24-hour access availability for members in South Carolina, according to requirements in the *SCDHHS Contract, Section 3.18*. Humana will use a formula to determine the appropriate number of Customer Care Specialists needed for the Member Call Center to answer member and provider calls. The call center is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						staffed Monday through Friday from 8 a.m. to 6 p.m. Outside of the normal business hours, the Interactive Voice Response system will instruct callers to call 911 for emergencies and will give the option to leave a message to which a response will be provided within one business day. The Member Services toll-free telephone number is provided in the Member Handbook and on the member ID card. Humana will monitor the Member Call Center's performance to ensure compliance with performance and response standards. Performance will be tracked for individual staff and aggregated to produce monthly quality reports for senior leadership. Call Center staff can access the Over the Phone Interpretation Services to provide translation services, in a minimum of 150 languages, for non-English-speaking callers, as described in Policy (Humana CSA Over the Phone Interpretation in at minimum 150 languages)-004.
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					The Member Handbook includes information about selecting a PCP upon enrollment and changing their PCP. Members can select one PCP for all members of the family or choose different

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						PCPs as appropriate for their needs. Humana automatically assigns a PCP after receiving the enrollment file from SCDHHS, according to procedures outlined in Policy (PCP Auto Assignment)-002. Policy (Primary Care (PCP) Changes)- 020, provides guidelines for the Customer Care Specialist to change a member's PCP when requested.
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy (CMP-Member Disenrollment)-001 defines the disenrollment process when initiated by Humana. Once a reason for disenrollment has been identified, Humana must request member disenrollment in writing, with supporting information, to SCDHHS who is responsible for disenrollment actions to remove a member from the Plan.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					Members will be able to access the member website, member portal, or the Member Handbook for information on preventive health services, available case management programs, and instructions to obtain educational support for medical, behavioral health, and pharmaceutical services. Additionally, Humana will deliver appropriate health education and information via email, free text messages, and social media posts.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Humana submitted examples of member education materials for various delivery formats that cover many health topics such as risk factors and wellness promotion, depression in children and teens, and a guide to preterm labor. Humana encourages members to participate in the wellness program, Go365 for Humana Healthy Horizons™, where members can earn rewards for completing certain preventive health services, such as, cervical cancer screenings, retinal eye exams, flu vaccines, and tobacco cessation.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					The EPSDT-Early and Periodic Services, Diagnosis, and Treatment Policy, states Humana tracks children eligible for recommended EPSDT services and immunizations and provides outreach to notify members to obtain the service. Discussions during the virtual onsite revealed reports generated from claims data assists in tracking and identifying members under 21 years of age who are due for an EPSDT exam. Those members will receive an automated phone message reminding them to schedule their exam. Additionally, the policy states providers are "educated on relevant quality performance measures that are related to EPSDT services, such as well-child visits and immunizations." The Provider Manual informs providers about the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						requirements for conducting EPSDT services for members through the month of their 21st birthday. EPSDT services are described and outlined according to guidelines from the AAP and Bright Futures Periodicity Schedule.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					The "On the Horizon" October 2021 member newsletter provides information regarding wellness and prevention topics, such well child visits and the Go365 Healthy Horizons wellness program.
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					The Care Management Program Description and the Member Handbook describe the Moms First maternity program, a program for pregnant members will provide rewards for completing certain prenatal and postpartum services and will provide education and support from trained nurses. Pregnant members are identified through a variety of means such as welcome calls, eligibility files, prenatal risk assessments, self-referrals, health risk assessments, physician referrals, or from within the plan.
III E. Member Satisfaction Survey						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO has a system in place to conduct a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:	X					Policy (Member Surveys) HUM-SC-QM-007-01 indicates Humana will contract with an NCQA-certified vendor to complete the member satisfaction survey. This policy lists the surveys to be conducted annually as the CAHPS Health Plan Survey, Adult and Child versions. The policy does not include the Children with Chronic Conditions survey. Onsite staff confirmed Humana will include the Child version for Children with Chronic Conditions survey annually. *Recommendation: Correct policy (Member Survey) HUM-SC-QM-007-01 and include the Children with Chronic Conditions version of the CAHPS survey.*
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					
4. The MCO reports the results of the member satisfaction survey to providers.	X					
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy (Medicaid and Dual Demonstration South Carolina Medicaid Grievance and Appeal Policy)-001A and Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E describes and outline Humana's grievance process according to requirements in *SCDHHS Contract Section 9 and 42 CFR § 438.400.* The South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance-001C document, describe the process

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						used by the Resolution Team to handle member grievances. Policy (Grievance and Appeals)-011, provides guidelines for Member Services staff to handle grievances and appeals.
1.1 The definition of a grievance and who may file a grievance;	X					
1.2 Procedures for filing and handling a grievance;		X				Humana processes grievance for benefits and services that are provided by the plan. Humana's staff and the Member Handbook confirmed the plan does not provide dental benefits to members and does not process grievances for dental services. However, the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C document states, "This process applies to medical and dental." The following documentation issues for filing and handling grievance were identified: •Grievance acknowledgement timeframes are documented in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document. However, acknowledgment timeframes are not included in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•The South Carolina Medicaid Grievance First Level Review-001F document (page 8) incorrectly documents the grievance filing timeframe as "30 calendar days." According to requirements in *SCDHHS Contract, Section 9.1.1.2.1,* grievances can be filed at any time. •The table of "Important Phone Numbers" on page 26 of the Member Handbook lists 1-800-372-2973 as the number to contact for grievances related to Medicaid Services. However, members are informed to call Enrollee Services (1-866-432-0001) on page 60 of the Member Handbook. *Quality Improvement Plan:* *•Remove the references to dental in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance -001C.* *•The grievance acknowledgement timeframes listed in the South Carolina Medicaid Grievance First Level Review-001F document and the South Carolina Medicaid First Level Review-Expedited Grievance- 001C document should be added to Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E.* *•Correct the grievance filing timeframe in the South Carolina Medicaid Grievance First Level Review-001F document as required by the SCDHHS Contract, Section 9.1.1.2.1.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Correct the grievance phone number listed in the Member Handbook, page 26.
1.3 Timeliness guidelines for resolution of a grievance;	X					Timeliness guidelines for grievance resolution are correctly documented in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E, the Member Handbook, and the Provider Manual indicating grievances are resolved within 90 calendar days of receipt. Additionally, the Grievance Acknowledgement Letter, and Grievance 14-day Extension Letter inform members that the grievance resolution timeframe can be extended 14 days and members have the right to file a grievance if they disagree with a decision to extend the timeframe.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					Policy (Medicaid and Dual Demonstration South Carolina Medicaid Grievance and Appeal Policy)-001A defines who can review and issue determinations for grievances related to clinical issues or denial of expedited appeal resolution.
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					Onsite discussions confirmed that Humana will log and maintain grievances in the grievance and appeals documentation system, MHK.
2. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Discussions during the onsite revealed the grievance and appeals documentation system, MHK, will allow staff to categorize and analyze

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						grievance data to determine patterns and opportunities for improvement.
3. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					Policy (Medicaid and Dual Demonstration South Carolina Medicaid Grievance and Appeal Policy)-001A, indicates medical records are confidential and will be handled according to HIPAA guidelines and any state requirements.

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 has a system in place for implementing 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				Humana provided the Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description, 2021. This program description provides the goals and objectives for the Healthy Horizon's program. Some of the goals included: developing clinical strategies and programs

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						that look at the whole person and integrating behavioral and physical health. The QI Program Description does not address the scope of the program. Page eight of the program description, under letter E, Quality Assessment and Performance Improvement Program Scope, only mentions "Humana provides Medicaid covered services to eligible Medicaid beneficiaries as a qualified Health Maintenance Organization." The QI program description will be reviewed and updated at least annually. *Quality Improvement Plan: Update Section E of the QI Program Description and Include the program's scope.* Page 27, under the section titled "Pharmacy Management" in the QI Program Description it mentions members receive a Humana designed Smart Summary RX bulletin offering guidance in changing medications to those with a lower co-payment while maintaining the same efficacy. It was unclear during the onsite discussion if this would be a program/tool used for Humana's Medicaid members. *Recommendation: Update the Pharmacy Management section of the QI program description if the Smart Summary RX bulletin would not be used for SC Medicaid Members.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					Listed as one of the goals and objectives in the QI program description is to provide a mechanism to detect both over and underutilization. Per QI program description, Humana will monitor utilization trends to identify potential over and underutilization issues. Further actions will be taken as warranted. There were no details included in the QI Program Description regarding the utilization data Humana plans to monitor. *Recommendation: Include in the scope of the QI Program the specific details regarding how Humana will monitor utilization data to identify potential over and underutilization issues.*
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					Humana provided a sample of the 2021 Quality Assessment and Performance Improvement Program work plan. The sample work plan included the activities, objectives, goals, responsible party and the frequency or timeframe for completion. The work plan will be updated as needed and at least annually.
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 Internal Board/Management Team has ultimate responsibility for the QI program. This Team has delegated authority for oversight to the Corporate Quality Improvement Committee. The Quality Assurance Committee is the local committee responsible for the development and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						implementation of Humana's quality improvement program in South Carolina. The QI Program Description outlines the various committees within the health plan. A description of the Health Services Organization National Committee was missing in the QI Program Description and the Pharmacy and Therapeutics committee was not included in the committee matrix on page 15. *Recommendation: Include a description of the Health Services Organization National Committee and add the Pharmacy and Therapeutics Committee on the committee structure/matrix on page 15 of the QI Program Description.*
2. The composition of the QI Committee reflects the membership required by the contract.	X					Humana's South Carolina Medicaid Medical Director will chair the QAC. Voting members include Humana's executives, medical and quality directors and other managers. Medical and behavioral health network providers will be included as non-voting members. *Recommendation: Consider including network providers as voting members of the QAC.*
3. The QI Committee meets at regular quarterly intervals.	X					The QAC will meet at least quarterly. A quorum has been defined as 50%of the voting members plus one.
4. Minutes will be maintained that document proceedings of the QI Committee.	X					Minutes will be maintained for each meeting.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. The process for collecting and reporting the performance measures are consistent with the requirements of the contract.	X					Humana's policy (Performance Measures)-005 (HUM-SC-QM-005-01) provides the process for collection and reporting of performance data. Performance data will be collected through a combination of various sources such as surveys, medical records, and claims or encounter data. Humana contracts with an NCQA-licensed organization to conduct the HEDIS audit. Page four of this policy under letter E, it incorrectly states, "All HEDIS, Health Outcomes Survey and CAHPS data will be reported consistent with Medicare requirements. All existing Part D metrics will be collected." *Recommendation: Correct the references to Medicare in policy (Performance Measures)-005 (HUM-SC-QM-005-01).*
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				Per policy (PIP) HUM-SC-MCD-QM-002-01, the Quality Director will work with Medicaid and Quality Improvement leadership to develop meaningful topics that considers the prevalence of a condition in the member population. This policy fails to include the details of how the performance improvement project topics are developed or selected, what potential data will be used, and the steps needed for approval of the project.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Update policy HUM-SC-MCD-QM-002-01 to include details regarding how performance improvement project topics are developed or selected, data sources, and the steps needed for approval.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects".	X					Humana provided the Performance Improvement Project template as an example of how performance improvement projects will be documented. This template meets the requirements, however CCME provided a few recommendations. Page six contained the barriers and interventions that addressed any barriers. CCME recommends separating the interventions and barriers documentation and identify the type of intervention (provider, member, system etc.). This allows for better documentation of improvement strategies and ongoing or changes in the strategy. The CMS protocol requires documentation of statistical evidence. Humana should include a section in the performance improvement project template that addresses statistical testing and presents the p-values from the tests. *Recommendation: Update the performance improvement project template to include evidence of the statistical testing if sampling is used, separate the interventions and barriers documentation, and include the type of intervention.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Noted as one of the responsibilities for Providers in the Provider Manual, "Provider agrees to comply with Humana Healthy Horizons in South Carolina's quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by Humana Healthy Horizons in South Carolina." Also, as part of the provider agreement providers agree to participate in Humana's quality improvement activities.
2. Providers will receive interpretation of their QI performance data and feedback regarding QI activities.		X				Humana will use The Stars Quality Report, which provides a list of members in their care that have a known gap in care. The Stars Quality Report is delivered via in-person visits, self-service access to a provider reporting system, mail, and secure fax. Policy (NNO 702-040 Physician Performance Measurement)-007 contains the SCDHHS Contract references and lists the purpose of the policy as "This policy recognizes our strategic goals of continuously improving the efficiency and effectiveness of our networks." Under the section labeled "Policy and Procedure," there is an embedded PDF file labeled NNO 702-040 Physician Performance. This embedded PDF file is Humana's corporate policy for improving the efficiency and effectiveness of commercial and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Medicare Advantage networks. This policy does not address the Medicaid line of business. *Quality Improvement Plan: Update policy (NNO 702-040 Physician Performance Measurement)-007 and include the specific for monitoring the SC providers performance.*
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 will be prepared annually and submitted to the QI Committee and to the MCO Board of Directors.	X					Per QI Program Description, Humana conducts an evaluation of the previous year's program. The evaluation will outline the accomplishments, analyzed data and outcomes compared to goals and includes limitations or barriers to meeting the goals and recommendations for the upcoming year. The evaluation is reviewed and submitted to the Quality Assurance Committee, the Corporate Quality Improvement Committee, and to the Board of Directors.

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 has in place policies and procedures that describe its utilization management program, including but not limited to:	X					The UM Program Description and several policies and documents describe and define Humana's UM service areas, such as service authorizations, pharmacy, care management, appeals, and grievances. The Utilization Management Program Description outlines the structure and defines the goals, scope, and staff roles for physical health, behavioral health, and pharmaceutical services for members in South Carolina.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Requirements for service authorization timeframes are documented in Policy (UM-Timeliness of UM Determinations)-005, the Member Handbook, and the Provider Manual. However, the Member Handbook

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and Provider Manual do not include information that service authorization decisions can be extended by 14 days when requested by the member or if the plan justifies an extension request to SCDHHS as indicated in the policy. *Recommendation: Edit the Member Handbook and Provider Manual to include information that service authorization decisions can be extended by 14 days when requested by the member or the plan, in accordance with the SCDHHS Contract, Sections 8.6.1.3 and 8.6.2.3.*
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					The UM Program Description indicates Humana's Preferred Provider Gold Carding Program will permit high performing providers to bypass the standard prior authorization process. The plan will review one year of providers' authorization history to determine their approval/denial rate, The Utilization Management Committee (UMC) will analyze service authorization trends and refer qualified providers to the Quality Team for review of a full year of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						additional data. The plan will conduct a final review process and scoring to determine if the provider meets criteria for Gold Card Status.
2. Utilization management activities will occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description states, "The Chief Medical Officer is a senior level physician who has ultimate responsibility for the oversight and overall implementation of the Utilization Management Program. Operational implementation of UM Program activities is delegated to Medical Directors and UM Health Service Director(s)." The Medical Director and Behavioral Health Medical Director support the CMO, will be involved in all UM and Quality Assessment Activities, and will be licensed to practice in South Carolina. The Behavioral Health Medical Director will have oversight over the BH UM Program. The Medical Director(s), UM Health Services Director(s) and the UM Manager(s) are responsible for the daily operation of the UM Program.
3. The UM program design will be periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program Description indicates the Medical Management Committee (MMC) has oversight of UM Program activities. It indicates the UM Program and Program Description will be reviewed, evaluated, and updated annually. The QI Program Description states the local UM Committee is responsible for reviewing UM activities, recommending improvement strategies, and providing

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reports to the Quality Assurance Committee (QAC) at least quarterly. Unlike the UM Program Description, the QI Program Description does not indicate the MMC is responsible for reviewing UM activities. CCME could not determine if network providers are included or will be included in discussions, evaluations, or updates related to UM Program activities at the plan-level. During the onsite, Humana staff explained the MMC includes network providers; however, the UM Program Description and QI Program Description do not indicate that providers from the network are members of the MMC. *Recommendation: Include in a document, such as the UM Program Description, QI Program Description, and SC Committee Charters, that participating network providers with various medical disciplines are included as members of the committee(s) responsible for overseeing UM activities.*
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria to be used are in place for determining medical necessity for all covered benefit situations.	X					UM standards and criteria are documented in the Program Description. Humana's UM criteria include evidence-based guidelines from MCG, South Carolina Medicaid manuals, medical coverage policies, and BH

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines from the American Society of Addiction Medicine (ASAM). Individual member circumstances and the local delivery system are considered when determining medical necessity.
2. Utilization management decisions will be made using predetermined standards/criteria and all available medical information.	X					Utilization decisions will be made according to service authorization procedures described in Policy (UM-Timeliness of UM Determinations)-005, the UM Program Description, and in the Standard Operating Procedure Administration (SOPA) documents. The SOPAs provide detail steps for the UM Reviewer to complete a clinical review and determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.		X				Hysterectomies, sterilizations, and abortions are mentioned in the Member Handbook and Provider Manual as covered benefits. However, the information is limited and does not include the specific requirements noted in the SCDHHS MCO Policy and Procedure Guide, Section 4. Also, Humana does not have a policy or process for how hysterectomies, sterilizations, and abortions will be handled by the health plan. *Quality Improvement Plan: Update the information in the Member Handbook and Provider Manual regarding the requirements noted in the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4. Develop a process for how Humana will handle hysterectomies, sterilizations, and abortions that meets the state and federal requirements.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					The UM Program Description states service authorization criteria are provided as guidelines for medical necessity and benefit coverage determinations. Medical Directors and physician reviewers consider pertinent clinical information and individual circumstances when making a decision outside of the screening criteria and can approve requested services when criteria is not met and clinical evidence supports the decision.
5. Utilization management standards/criteria will be consistently applied to all members across all reviewers.	X					Policy Utilization Management Inter-Rater Reliability (IRR) and the UM Program Description describes Humana's process for conducting inter-rater reliability testing. At least annually, Humana business leadership will conduct IRR testing to assess the consistency with which physician and non-physician reviewers apply UM criteria. Reviewers are tested after 3 months of employment. The established passing score is 85% for physician reviewers and 90% for non-physician reviewers.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Humana Pharmacy Solutions (HPS) is the pharmacy benefit manager for Humana. Pharmacy benefit information is available in the Pharmacy Program Description, the Member Handbook, and the Provider Manual. Humana will ensure access to covered drugs using the PDL that will identify formulary restrictions by indicating medications requiring prior

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						authorization, limitations, or step therapy. Review of the formulary list, dated April 5, 2021, confirms drugs are listed by label name, generic name, specialty status and applicable limitations. Policy (HCPR&MIT Medicaid Coverage Determination Policy)-013 and the Preferred Drug List Roadmap states prior authorization is required to receive drugs that are not listed in the PDL and determinations will be made within 24 hours of receipt. Members and providers will receive written notice of negative PDL changes at least 30 days prior to the effective date and changes will be posted on the website within 30 days, as discussed during the onsite and reported in Policy (Formulary Change Notification Process)-005. The Pharmacy and Therapeutics (P&T) Committee includes practicing physicians and pharmacists who participate in making decisions regarding PDL management activities. The committee is responsible for PDL development, drug utilization reviews, and evaluating pharmaceutical products.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					The Pharmacy Program Description and Policy (Non-Formulary Exceptions)-023 include Humana's process for handling prior authorization requests for medications that are not listed in the PDL. Members can obtain mail-order medications from Humana Pharmacy and specialty medications from Humana

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Specialty Pharmacy at no cost to the member. Humana does not require members to obtain certain medications from a central "specialty pharmacy."
7. Emergency and post stabilization care will be provided in a manner consistent with the contract and federal regulations.	X					Humana will cover and pay for Emergency and Post stabilization services according to requirements in the *SCDHHS Contract, Section 4.2.11* and *42 CFR 438.114* and outlined in Policy (UM- Core Benefits and Services)-007 and the Specific Core Benefit Policy. The UM Program Description provides a brief description of Emergency Care, indicating that referrals and authorizations are not required, and Humana will pay for services obtained if the provider is either in or out of the network. It does not include a description of post stabilization services which often accompanies emergency services. *Recommendation: Include a description for post stabilization services in the UM Program Description to accompany the description of emergency services.*
8. Utilization management standards/criteria are available to providers.	X					The Provider Manual informs medical and behavioral health providers to contact the UM Department via email for information on the criteria Humana used to determine an adverse benefit determination made. Adverse Benefit Determination letters provide instructions for the requesting provider to have a peer-to-peer discussion with a Medical Director from Humana.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
9. Utilization management decisions will be made by appropriately trained reviewers.	X					The UM Program Description describes the roles and responsibilities of UM staff and indicates the qualifications of appropriate professionals making UM determinations. Non-clinical staff are supervised by a licensed health professional and can approve requests that do not require clinical review, as noted on the prior authorization list. Level one reviews are conducted by experienced nurses or behavioral health professionals with an active and valid license in South Carolina. A licensed physician or other appropriately licensed health care professional reviews all medical necessity authorizations resulting in an adverse benefit determination. The List of Physician Reviewers reflects physicians who are available for utilization consultation and review, along with their specialty. UM staff receive orientation and continuing education related to their job responsibilities.
10. Initial utilization decisions will be made promptly after all necessary information is received.	X					
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider will be made to obtain all pertinent information prior to making the decision to deny services.	X					The UM Program Description explains Humana will request necessary clinical information to make a medical necessity determination. If additional information is required, the first level reviewer will make two attempts using two different methods to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						request additional information from the provider or the member. The Medical Director can issue a denial for insufficient clinical information if the requested information is not received within one day.
11.2 All decisions to deny services based on medical necessity will be reviewed by an appropriate physician specialist.	X					Adverse Benefit Determinations will be made by the Medical Director or other appropriately licensed health care professional as outlined in the UM Program Description. Available physician reviewers and appropriately licensed professionals include pharmacists from Humana Pharmacy Solutions, psychologists or psychiatrists from FOCUS Health, Inc. and, various specialties from Network Medical Review (NMR) Co. Ltd.
11.3 Denial decisions will be promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Humana will ensure written adverse benefit determination notices are mailed to providers and members in a timely manner, according to the processes described in Policy (UM-Timeliness of UM Determinations)-005.
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO has in place 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 (Medicaid and Dual Demonstration South Carolina Medicaid Grievance and Appeal Policy)-001A describes and outline Humana's appeals process according to requirements in *SCDHHS Contract Section 9* and *42 CFR § 438.400*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E contains only SCDHHS Contract requirements and does not specify Humana's processes for appeals processing. *Recommendation: Revise Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E to describe processes followed for appeals processing.*
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;		X				Definitions of the terms "appeal" and "adverse benefit determination", and a description of who may file an appeal, are documented in the South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E, Provider Manual, and Member Handbook. Additionally, the definition of an authorized representative and the requirement that providers and other authorized representatives must have a member's written consent to file an appeal on their behalf are documented across all areas. The following issues with appeals definitions were noted: •The term "appeal" is not completely and clearly defined in the Key Words section and in the appeals section of the Member Handbook. It does not specify that an appeal is a request to review an adverse benefit determination as noted in the *SCDHHS Contract*. •The term "adverse benefit determination" is not defined or described in the Member Handbook.

STANDARD	SCORE					COMMENTS
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						•Policy (South Carolina Medicaid Standard Appeal First Level)-001G refers to Kentucky Medicaid on the top of page three for definitions. *Quality Improvement Plan: Edit the Key Words section and appeals section in the Member Handbook to correctly define the term "appeal" according to 42 CFR §438.400 (b). Include a definition and description of the term "adverse benefit determination" in the Member Handbook as per the SCDHHS Contract, Section 9.1 (b). Remove the reference to Kentucky Medicaid from Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001G.*
1.2 The procedure for filing an appeal;		X				Humana processes appeal requests for core benefits and services that are provided by the plan. Policy (South Carolina Medicaid Standard Appeal First Level)-001G states, "This process applies to medical and dental." The Member Handbook and Humana's staff confirmed the plan does not provide dental benefits to members and does not process appeals for dental services. Requirements for filing an appeal are documented in the South Carolina Medicaid Grievance and Appeal Policy DRAFT-001E, the Member Handbook, the Provider Manual, and in letters. The Appeal Form and Appointment of Representative Form are available in the Member Handbook.

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						The following documentation issues with appeal procedures were identified and discussed during the onsite: •Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B use the terms "notice of action" and "adverse determination notice" instead of the term "adverse benefit determination notice" or "notice of adverse benefit determination" according to *SCDHHS Contract, Section 9.1.5.* •Also, the policies do not include the requirement that the plan will provide assistance with completing appeals forms or procedures, as required in *Contract Section 9.1.4.2* •Documentation of the requirements that Humana will provide an opportunity for members to present evidence related to their appeal, inform them of the limited time available to do that prior to the resolution (*SCDHHS Contract, Section 9.1.4.4.2.*) and inform members they can examine their appeal case file before and during the appeal process (*SCDHHS Contract, Section 9.1.4.4.3.*), is either incomplete or omitted from Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: *•Remove the dental reference from Policy (South Carolina Medicaid Standard Appeal First Level)-001G.* *•Edit Policy South Carolina Medicaid Standard Appeal First Level-001G and Policy South Carolina Medicaid Expedited Appeal First Level-001B to include the terms "adverse benefit determination notice" or "notice of adverse benefit determination" instead of the terms "notice of action" and "adverse determination notice" and include the requirement that Humana will provide assistance with appeals procedures.* *•Edit Policy South Carolina Medicaid Standard Appeal First Level-001G, Policy South Carolina Medicaid Expedited Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter to include the requirement that Humana will provide an opportunity for members to present evidence related to their appeal, inform them of the limited time available to do that prior to the resolution and inform members they can examine their appeal case file before and during the appeal process according to requirements in SCDHHS Contract, Sections 9.1.4.4.2. and 9.1.4.4.3.*
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	X					Policy (Medicaid and Dual Demonstration South Carolina Medicaid Grievance and Appeal Policy)-001A defines who can review and determine appeals related to clinical issues or deny expedited appeal requests. Additionally, the Member Handbook and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
appropriate medical expertise who has not previously reviewed the case;						Provider Manual communicates that decision-makers who are involved in an appeal were not involved in any previous level of that review.
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy (South Carolina Medicaid Expedited Appeal First Level)-001B describes the process for expedited appeal requests. A physician or other appropriate clinical peer of a same-or-similar specialty will determine if the request meets criteria for an expedited review and a decision will be made within 72 hours from Humana receiving the request.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;		X				Humana will resolve standard appeals and give notice within 30 calendar days of receipt and will resolve expedited appeals and provide notice within 72 hours of receipt, as noted in Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E, Policy (South Carolina Medicaid Expedited Appeal First Level)-001B, and Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E. The following documentation issues with appeal timeframe guidelines were identified and discussed during the onsite: •Policy Medicaid Standard Appeal First Level)-001G does not include the requirement that notice of appeal resolution must be provided within 30 days of receipt of the appeal request. •Policy (Medicaid Expedited Appeal First Level)-001B, does not include the requirement members will be informed of their right to file a grievance if the

STANDARD	SCORE					COMMENTS
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						member disagrees with the denial of expedited processing of an appeal. *Quality Improvement Plan: Edit Policy (Medicaid Standard Appeal First Level)-001G to include the requirement that standard appeal resolution notice must be provided within 30 days of receipt of the appeal request. Edit Policy Medicaid Expedited Appeal First Level)-001B, to include the requirement to inform the member of their right to file a grievance if the member disagrees with the denial of expedited processing of an appeal. Refer to requirements in SCDHHS Contract, Section 9.1.4.41 to 9.1.4.4.3.*
1.6 Written notice of the appeal resolution as required by the contract;	X					Policy (South Carolina Medicaid Grievance and Appeal Policy DRAFT)-001E and appeal letter templates such as Appeal Overturn and Appeal Upheld, addresses all requirements for appeal resolution notices, according to *SCDHHS Contract Section 9.1.6.2.2 to 9.1.6.3.1.3*. Additionally, State Fair Hearing information is provided in the Member Handbook and the Provider Manual. However, Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B do not include information that members have 120 days from the date on the resolution notice to request a State Fair Hearing.

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						Recommendation: Edit Policy (South Carolina Medicaid Standard Appeal First Level)-001G and Policy (South Carolina Medicaid Expedited Appeal First Level)-001B to reflect that members have 120 days from the date on the resolution notice to request a State Fair Hearing, according to requirements in SCDHHS Contract, Section 9.1.6.3.1.1.
1.7 Other requirements as specified in the contract.	X					
2. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					The UM Program Description indicates evaluation of member appeal data will be included in the annual UM Program Evaluation conducted by the UM Health Services Director.
3. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					UM Program Description states Humana will ensure appeals documentation is shared with appropriate internal staff and will maintain strict confidentiality of medical records within HIPAA guidelines.
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its case management/care coordination programs.	X					Humana's Care Management Program is outlined in the 2021 Care Management Program Description. It defines methods and criteria for enrollment, describes process used to provide coordinated services for medical and behavioral health needs, and issues related to social determinants of health (SDOH) for members in South Carolina. The CM Program

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	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						works collaboratively with the UM and QM departments. Policy Program Description (Case Management)-004 provides definitions and applicable references to the SCDHHS Contract and additional policies such as Policy (Health Risk Assessment (HRA))-001 provide guidance to staff for rendering CM services.
2. The MCO has processes to identify members who may benefit from case management.	X					The Case Management Program Description includes methods for identifying and referring eligible members into case management. Humana uses predictive modeling tools to identify and stratify members for case management services based on risk category.
3. The MCO provides care management activities based on the member's risk stratification.	X					Humana has a person-centered model that encompasses a multi-disciplinary team approach to Care Management as outlined in the Care Management Program Description. Members identified as having primary behavioral health needs will lead by a Behavioral Health Care Manger. Eligible members are assessed for the appropriate level of care management services. CM services are provided according to the following categories: •CM Low Risk- members who did not meet requirements for other levels of CM and focuses on prevention and wellness support.

STANDARD	SCORE					COMMENTS
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						•CM Moderate Risk- is a higher level of service that includes clinical needs, care plan development and addressing SDOH. •Intensive CM (ICM) for High-Risk Enrollees- requires intensive and highly focused attention for clinical and SDOH needs, and care plan development. •Complex CM is the highest risk category for members as having the highest utilization of high-cost services based on Medicaid Severity Predictive Model, and it includes all activities in the lower risk categories. The Chronic Conditions Management (CCM) program provides disease specific education and clinical interventions focusing on behavioral change and self-management activities to reduce risk and manage the member's chronic disease.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.		X				Comprehensive assessments are conducted by Humana Care Managers and cover various life topics such as health risks, cultural and linguistic needs, and behavioral health status. The comprehensive assessment and care plan will be completed within 30 days for all enrollees including those stratified to High and Complex risk. CCME could not identify Humana's process for ensuring Targeted Care Management (TCM) services are provided. During the virtual onsite Humana staff explained that their approach to TCM services is described in the Care Management Program

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						Description under the "Coordinating CM With External Partners" and the "Enrollees with Special Health Care Needs (SHCN)" sections. However, the sections identified do not define nor describe TCM, or identify the population to receive TCM services according to requirements in the *SCDHHS Contract, Section 4.2.27.* *Quality Improvement: Define and describe, in a program description or other document, Humana's process for ensuring TCM services are provided to the identified population according to requirements in SCDHHS Contract Section 4.2.27.*
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy (UM)- 003, -Continuity of Care and Care Transitions defines and describes Humana's approach to providing transition of care services.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					Discussions during the onsite revealed a Transition Coordinator has not been designated and recruitment efforts are in progress. An updated South Carolina Staffing Memo listing the status of Key Personnel positions and an updated Organization Chart reflecting status of the Transition Coordinator were provided for review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Continue recruitment efforts for a Transition Coordinator to ensure compliance with SCDHHS Contract, Section 5.6.2.
6. The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary.	X					The Care Management Program is evaluated at least annually, results are evaluated for effectiveness and are reported the Medical Management Committee (MMC) and QAPIC.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract.		X				A Fraud, Research, Analytics and Concepts (FRAC) document, UM Data Plan, and UM Program Description were submitted to review Humana's approach for evaluating over and under-utilization. However, these documents did not include a defined timeline for utilization data analysis, specific areas of interest (readmission, ER rates, pharmacy, etc.), who will set target rates, who will assist with monitoring and interventions, and plans to mitigate when issues are identified. *Quality Improvement Plan: Develop a plan or process for how Humana will monitor over and underutilization.*

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Humana provided the following delegation templates for review: •Delegated Services Addendum •Business Associate Agreement •Business Continuity Attachment •Information Security Agreement •Master Business Agreement •South Carolina_Subcontractor Addendum_Medicaid The Subcontractor Monitoring and Oversight Plan states Humana retains all responsibility for services rendered under the SCDHHS Contract, regardless of whether a third party is engaged. The Delegation Policy attached to Policy (Delegation)-001 defines processes for delegation approval and states the Delegated Services Addendum and Delegation Attachment must be executed for each delegated function. The Delegation Addendum with any applicable attachments will be maintained by the Delegation Compliance department. The written Delegation Services Addendum and Delegation Attachment(s) must describe the activities and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						responsibilities of Humana and the Delegated Entity; require at least semiannual reporting; and describe how Humana evaluates the delegated entity's performance and the remedies available if the delegate does not fulfill its obligations.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.		X				Policy (Delegation)-001 states, "The Delegation Compliance department will perform a pre-delegation audit prior to any function being delegated to a prospective entity upon receipt of the Request for Delegation form and the Pre-delegation Questionnaire (claims delegation only). The pre-delegation audit will include evaluation of a prospective delegate's compliance and performance capacity against state, federal, accreditation and Humana standards…" The policy lists items that will be evaluated during the pre-delegation audit. Issues identified in the Delegation Policy attached to Policy (Delegation)-001 include: •Requirements for sub delegation under multiple headings in the policy do not address the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor. •The policy addresses checking the OIG and SAM during the pre-delegation assessment but does not address the queries on an ongoing basis. Refer to the *SCDHHS Contract, Section 2.5.13.*

STANDARD	SCORE					COMMENTS
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						Quality Improvement Plan: Revise the Delegation Policy attached to Policy (Delegation)-001 to include the requirement that SCDHHS must receive prior notification of any further delegation by a subcontractor and to include requirements for checking the OIG and SAM on an ongoing basis.