CCME

2022 External Quality Review

HUMANA HEALTHLY HORIZONS

Submitted: March 31, 2022

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

Table of Contents

EXECUTIVE SUMMARY

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

The goals and objectives of the review are to:

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

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

Summary and Overall Findings

Federal regulations require MCOs to undergo a review to determine compliance with federal standards set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. 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 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

Administration:

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

Humana has developed policies and procedures to ensure adherence to the SCDHHS Contract and federal regulations. Annual policy reviews are conducted at the department and management level. Issues specific to policy review timeliness, revisions, and policy content were identified and discussed during the onsite. Staff have access to policies and are alerted to new policies and policy revisions by departmental leadership.

The organizational chart demonstrates that sufficient staffing is available to meet *SCDHHS Contract* requirements. Policy (Humana Corporate Compliance Plan)-001C, outlines Humana's guidelines for each associate and all business entities striving to create a workplace climate in which ethics are integral to day-to-day operations. The Ethics Every Day document provides definitions of key ethical principles, examples of potential violations, reporting processes, potential outcomes, and subsequent investigations.

Avenues for reporting suspected fraud, waste, and abuse (FWA) are clearly defined on Humana's website, the Member Handbook, and the Provider Manual. Telephonic, electronic, and mail reporting options are provided. Multiple teams coordinate to identify and investigate suspected FWA referrals. Humana's code of conduct and Ethics Every Day document provide guidelines for FWA violations and sanctions. Internal monitoring and auditing are conducted to identify compliance risks. The Enterprise Investigations Consortium (EIC) conducts investigations for potential misconduct, FWA, criminal activity, and ethics and compliance concerns, including concerns received via the Ethics Help Line, to provide a basis for managing risk.

The Corporate Compliance Committee has been established to monitor significant issues of risk, metrics, training, and adherence to compliance policies to ensure the program is effective. This committee is chaired by the Chief Compliance Officer and is comprised of Humana's CEO, executive leaders, compliance officers, the Chief Audit Officer, and other

senior leaders. The Committee meets on a quarterly basis, and more frequently as needed. An issue with documentation of the frequency of committee meetings was identified and discussed during the onsite.

All staff, including the Chief Executive Officer, all senior leaders, the Board of Directors, and contingent labor are required to attend annual trainings related to compliance and fraud, waste, and abuse.

Information Systems Capabilities Assessment (ISCA)

Humana's ISCA documentation indicates the MCO is capable of fulfilling the *SCDHHS Contract* requirements. Humana's policies and procedures align with industry best practices. In addition to sound Information and Technology policies, the organization has deployed monitoring tools to ensure IT systems function as designed and provide insight if there is an issue requiring investigation. Finally, Humana's staff receives IT training on a scheduled basis to ensure they are up to date on secure IT operations and data handling.

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

Processes and requirements for initial credentialing and recredentialing of practitioners and organizational providers are found in the Credentialing & Recredentialing Program Description and in enterprise-wide and local health plan policies. However, the South Carolina requirement for querying the SCDHHS Termination for Cause List was not addressed. As a result of a finding from the 2021 Readiness Review, Humana has implemented the South Carolina Medicaid Credentials Committee, which began operations in December 2021. The committee is chaired by the Humana Medical Director and membership includes network practitioners with specialties of Family Practice, Obstetrics and Gynecology, Psychiatry, a pharmacist, and a nurse practitioner.

Deficiencies noted in credentialing and recredentialing files included determination letters dated prior to the determination date and failure to collect collaborative agreements between nurse practitioners and supervising/collaborating physicians. Both were uncorrected deficiencies from the 2021 Readiness Review. Additional deficiencies noted during the current EQR included lack of evidence of queries of the SCDHHS Providers Terminated for Cause List and the Social Security Administration's Death Master File. Additionally, the query of the SCDHHS Excluded Provider's Report was conducted three months after the determination date for one organizational provider file.

Humana monitors the adequacy of its provider network by conducting network analyses, monitoring member-to-provider ratios, monitoring provider panel status, and performing

Geo Access mapping. The SC Medicaid Network Availability and Access policy appropriately defines geographic access standards for primary care providers (PCPs), required specialists, and hospitals. Humana reported some previous network gaps have been closed and efforts continue to recruit providers to close remaining gaps.

The SC Medicaid Network Availability and Access policy defines appointment availability standards and processes for assessing provider compliance with the standards through member satisfaction survey results, complaint and grievance data, requests for out of network provider agreements, and Mystery Shopper Survey results. The policy does not specify the frequency for conducting the Mystery Shopper Surveys. Humana reported the first Mystery Shopper Survey will be conducted in July 2022.

For the current EQR, CCME conducted a PCP-focused provider access study from a list of current Humana network providers. Of 2,170 unique PCPs identified, a sample of 172 providers was randomly selected for the access study. The successful contact rate was 55% (84 out of 154) when omitting calls answered by voicemail messaging services. The most common reason for unsuccessful contacts was that the provider was no longer an active PCP at the location. When asked if the provider accepted Humana, 70 of the 84 providers (83%) confirmed they accept Humana. The access study also assesses routine appointment availability by asking "Is there a new patient appointment in the next 4 weeks for this provider?" For Humana, 11 of 49 providers who answered the question (22%) did not meet the requirement of a routine appointment within 4 weeks.

Processes for initial and ongoing provider education are detailed in Policy and Procedure (Provider Training)-009. Several issues were noted in the policy, including missing information, a reference to the Provider Manual for a health plan in a different state, and several references to a New Provider Orientation Checklist that Humana staff confirmed is not used. The Provider Manual is a comprehensive resource for providers; however, information about some covered benefits is incomplete.

Medical record documentation standards and the provider medical record review (MRR) process are found in Policy (Medical Record Review) – 013. The policy does not define the frequency of the medical record reviews. Onsite discussion confirmed Humana will conduct MRR at least annually and more often if needed. Humana staff confirmed that an MRR was not conducted in 2021 but one is planned for 2022.

Member Services:

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

Member Services policies address member rights and responsibilities. Information about member rights and responsibilities are also found in the Member Welcome Packet, the Member Handbook, the Humana website, and in Policy (Member Rights)-028.

Processes are in place and were shared during onsite discussion about the assurance of the receipt of new member information. Welcome Packets include an introduction letter, a Plan Booklet providing an overview of benefits and services, member rights and responsibilities, a Health Risk Assessment form, consent for release of Protected Health Information, 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, Member Handbook, and Provider Directory.

Policies indicate members are informed of benefits, limits to coverage, services requiring prior authorization, and changes in benefits. During the onsite discussion, services were identified that were not addressed or where additional detail is needed in the Member Handbook and on the Humana website.

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 clearly described levels of care for routine, urgent, or emergent healthcare needs. The Member Handbook indicates that members will be notified within 30 days of changes in benefits.

Annually, Humana conducts a Member Satisfaction Survey. Humana has contracted with SHP Analytics to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey for the Adult, Child, and Child with Chronic Conditions populations. SHP Analytics is on track for reporting the results in June/July 2022. Therefore, the Validation of the Member Satisfaction Survey was not conducted for this EQR. Humana also mentioned the timeline for administering the ECHO survey is scheduled to start in March 2023.

Grievances

The Grievance process is outlined in Policy (Grievance and Appeals)-011 and on the Humana website. Members or their representatives are informed of their right to file a grievance at any time. The term “grievance” is consistently defined in Policy (Grievance and Appeals)-011, the Humana website, Member Handbook, and Provider Manual. Timelines are clearly outlined in policy (South Carolina Grievance First Level Review)-001F, on the Humana website, and the link to the Appeal, Complaint or Grievance Form. Humana outlines in policy that Grievances are acknowledged within five business days with resolution to be completed within 90 calendar days. Grievances are logged, categorized, analyzed, and reported internally per policy and Contract requirements.

Humana submitted seven grievance files for review. Two of the seven files did not meet Humana’s timeliness policy for sending an acknowledgement letter. One file was noted as still in progress. This grievance was received on November 16, 2021 and should have been resolved by February 14, 2022. There was no information regarding a request for an extension. In one file, the member complained that she was unable to locate a PCP in her

area and requested a list of PCPs. Humana attempted to reach the member by phone without success. Humana sent the member resolution letter 10 days after receipt without providing the member with a list of PCPs.

Quality Improvement:
42CFR §438.330, 42 CFR §457.1240 (b)

Humana has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided. The 2021 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description was submitted for review. The scope of work described in the program description includes areas such as preventive health, quality of services, over- and underutilization, population health management, behavioral health, continuity and coordination of care, accessibility and availability of care, member and provider satisfaction, and health outcomes. During the Readiness Review, it was noted that the program description did not include the scope of work. Humana corrected this deficiency.

Humana develops an annual work plan that specifies activities planned to assess the quality and appropriateness of care furnished to members. The 2021 and 2022 QI work plans were provided for review. There were several goals that have not been determined throughout the 2022 work plan.

Humana's Quality Assurance Committee (QAC) is responsible for directing and reviewing quality improvement activities and taking appropriate actions as needed. Humana's Medical Director serves as chair for the QAC. Members of the committee include senior staff department leads, directors, and managers. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. However, the membership list and committee minutes for this committee did not include any participating network practitioners. Humana indicated recruitment efforts are underway to recruit providers.

The QAC meets at least quarterly, and a quorum has been defined as 50% of the voting members plus one. Committee minutes for meetings held in September 2021, November 2021, and February 2022 were provided. The minutes were very detailed and included extensive reports and discussions.

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

Humana evaluates the effectiveness of the QI program and activities conducted in the previous year. Per Humana, with 2021/2022 being the first calendar year of operations, the QI program evaluation is scheduled to be completed in August 2022.

Performance Measure Validation

Humana did not provide performance measures for validation. Per onsite discussion, Humana expects to have reported rates next year.

Performance Improvement Project Validation

There were no projects submitted for validation. Per onsite discussion, the health plan is reviewing baseline data, other data sources, and forming work groups to begin the discussions regarding topics for performance improvement projects.

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)

Humana has developed a program description and several policies and documents that guide staff in the implementation of utilization management functions. The Utilization Management Program Description 2021 describes and defines Humana's Utilization Management (UM) service areas, such as service authorizations, pharmacy, care management, appeals, and grievances. The daily oversight and operating authority of UM activities is delegated to the Medical Management Committee. Humana indicated that, due to limited data and medical monitoring metrics discussed in other meetings and committees, this committee was dismantled. The responsibilities of the Medical Management Committee were transferred to the Quality Assessment Committee

Humana's Medical Director oversees all aspects of the UM Program. A registered pharmacist oversees the implementation, monitoring and directing of pharmacy services.

Humana has developed a list of services that require prior authorization, and the website provided multiple resources and links for providers regarding the prior authorization process and what requires authorization. Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provide a summary of the process used to manage the prior authorization list. Both policies contain basically the same information. Policy (Preauthorization List (PAL) Governance-001 was watermarked draft and had an issue date of 02/25/2022. No explanation was provided regarding the purpose of both policies.

Medicaid Coverage Policies, MCG, and American Society of Addiction Medicine (ASAM) are the criteria used for the initial review of authorization requests. Timeliness for Utilization Management decisions is included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Focus Health, Inc. conducts Behavioral Health Utilization Management reviews. The Focus policy, Initial Case Review V 14.0, contained the timeframes for completing requests for peer reviews. This policy incorrectly listed

the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.24.*

Humana's UM Program description and Utilization Management Inter-Rater Reliability policy provided a summary of the Inter-Rater Reliability (IRR) monitoring process used to assess consistent decision-making for all staff who render clinical determinations. To date, Humana has not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.

Humana provided several letter templates for notifying providers and members of adverse benefit determinations. The Notice of Denial and the Notice of Partial Denial did not include information that standard appeal decisions can be extended by 14 days when requested by the member or by the plan. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation to the member for when to use this contact information.

The review of approval and denial files confirms Humana performs reviews using appropriate criteria with notification promptly communicated to providers and members, as applicable. UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.

The *SCDHHS Contract, Section 4.2.21.2.3* requires the health plan to publish negative Preferred Drug List (PDL) changes on Humana's website at least 30 days prior to implementation. Notices for PDL changes were found on Humana's website; however, the effective date for the change and/or when the notice was published to the website were unclear. The notice contained a date at the top of the page without an explanation of what the date represents.

Appeals

Humana has several policies that describe appeals processes. Policy (South Carolina Medicaid Grievance and Appeal Policy) – 001 and policy (South Carolina Medicaid Grievance and Appeal Policy Draft)-001E only included the *SCDHHS Contract* references and did not specify Humana's process for handling appeals. The process for handling appeals is contained in Policy (South Carolina Medicaid Standard Appeal First Level) – 001G, Policy (South Carolina Medicaid Expedited Appeal First Level) – 001B, and Policy (South Carolina Medicaid Fair Hearing External Second Level Review)-001D. Information on the appeal process was also found in the Member Handbook, the Provider Manual, and on Humana's website.

Humana provided one appeal file for review. The file reflected the acknowledgement and resolution was completed timely. An appropriate physician reviewed the appeal and made the decision to uphold the original denial. The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." Also, the language used to describe why the denial was upheld appeared to be above the 6th grade reading level.

Case Management

Humana's Care Management (CM) Program Description provides an overview of the program and defines the program's goals, criteria for enrollment, methods and processes for enrollee identification and assessment, and management and evaluation of enrollee care and outcomes. The CM Program Description lacks detail about the program's structure, such as departmental oversight, leadership, staffing positions, etc., and does not provide detailed information about conducting satisfaction surveys with members who have been enrolled in the complex case management/disease management programs. Standard Operating Procedures supplement the program description and provide guidance and instruction for staff conducting Care Management activities.

Case Management files reflected documentation of member consent for participation in Case Management activities. Documentation in the files confirmed staff consistently evaluate member needs, refer members to available community resources, assist with scheduling provider appointments and transportation, and address identified needs in care plans.

Humana corrected a deficiency identified during the Readiness Review in 2020 related to lack of documentation of processes for ensuring Targeted Care Management (TCM) services are provided.

Evaluation of Over and Underutilization

Policies for drug utilization, the Utilization Management Data Plan, and the Fraud, Research, Analytics and Concepts report for fraud management were submitted. The Utilization Management Data Plan offered some utilization indicators that will be monitored, including acute admits per 1000, inpatient days per 1000, readmission rates, ER visits per 1000 and others. All monitoring and assessments will be done by the Medical Management team and shared with Quality Management team. There was not a specific policy or action steps planned for addressing over- and underutilization. This was an issue identified during the Readiness Review. In response to this deficiency, the Utilization Management Data Plan stated that the Medical Management Committee "creates plans to mitigate when issues are identified." However, the process for how that is conducted was

not clearly documented. During the onsite, staff indicated the Utilization Management Team was still building this out.

Delegation:

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

Processes and requirements for delegation are included in policies and in the 2021 Subcontractor Monitoring and Oversight Plan. Humana conducts pre-assessments of all potential delegates to ensure they can conduct the delegated functions in compliance with all standards and requirements. When delegation is approved, written delegation agreements are executed and specify the activities delegated, responsibilities of both the delegated entity and Humana, requirements for complying with Humana, state and federal law and accreditation organization requirements, processes for evaluating performance, and actions that may result if the delegate does not fulfill its obligations. Formal, annual evaluations are conducted to assess delegate performance and compliance to required standards. Ongoing monitoring is conducted via routine delegate reporting and Joint Operations Committee meetings.

Oversight documentation submitted by Humana confirms the plan is conducting appropriate oversight for all delegates. CCME offered a recommendation to improve the Credentialing Annual Audit Tool used to assess credentialing delegates so that it is clear Humana ensure the delegates are querying required SCDHHS Program Integrity lists.

State Mandated Services:

42 CFR § Part 441, Subpart B

Through documentation review and onsite discussion with Humana staff, it was determined that Humana covers all required core member benefits.

A policy and/or procedure was not identified describing processes for monitoring provider compliance specific to performing EPSDT/Well-Care services for members or for administering immunizations. Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations or with performing EPSDT/well care services.

Humana did not implement the Quality Improvement Plans corrections to address deficiencies identified during the 2021 Readiness Review related to: collecting full collaborative agreements between nurse practitioners and their supervising/collaborating physician(s) at initial credentialing and recredentialing; ensuring letters notifying providers of credentialing and recredentialing determinations are dated on or after the date of the credentialing/recredentialing determination; and developing specific policy or action steps for addressing the monitoring of over- and under-utilization.

Quality Improvement Plans and Recommendations from Previous EQR

During the Readiness Review, there were 19 standards scored as "Partially Met" and 9 standards scored as "Not Met." Following the Readiness Review, Humana submitted a Quality Improvement Plan to address the deficiencies identified. CCME reviewed and accepted the Quality Improvement Plan on June 14, 2021. The following is a high-level summary of those deficiencies:

- 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.
- Seven key positions are 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.
- 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.
- 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 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.
- 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.
- 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.

During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plans for credentialing and recredentialing (credentialing determination letter dates and collection of collaborative agreements for nurse practitioners) and documentation of the process for monitoring over-and under-utilization data were not implemented.

Conclusions

Overall, Humana met most of the requirements set forth in *42 CFR Part 438 Subpart D* and the Quality Assessment and Performance Improvement (QAPI) program requirements described in *42 CFR § 438.330*. *Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards* provides an overall snapshot of Humana's compliance scores specific to each of the 11 Subpart D and QAPI standards above.

Table 1: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Standards	Category	Total Number of Standards Evaluated	Number of Standards Scored as "Met"	2022 Overall Score
Provider Services, Section II. B. Adequacy of the Provider Network	• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	7	7	**100%
Utilization Management, Section V. D. – Care Management Section V. E. – Transitional Care Management	• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	8	8	100%
Utilization Management, Section V. B. – Medical Necessity Determinations	• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	14	11	79%
Provider Services, Section II. A. – Credentialing and Recredentialing	• Provider Selection *(§ 438.214, § 457.1233)*	39	30	77%
Administration, Section I. E. - Confidentiality	• Confidentiality *(§ 438.224)*	1	1	100%
Member Services, Section III. G. – Grievances Utilization Management, Section V. C. - Appeals	• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	20	18	90%
Delegation Section	• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	2	2	100%

Standards	Category	Total Number of Standards Evaluated	Number of Standards Scored as "Met"	2022 Overall Score
Provider Services, Section II. D. – Primary and Secondary Preventive Health Guidelines Provider Services, Section II. E. – Clinical Practice Guidelines for Disease and Chronic Illness Management	• Practice Guidelines *(§ 438.236, § 457.1233)*	11	11	100%
Administration, Section I. C. – Management Information Systems	• Health Information Systems *(§ 438.242, § 457.1233)*	7	7	100%
Quality Improvement Section	• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	11	10	**91%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100*
*** The Standards Not Evaluated were removed from the denominator and numerator.*

As noted in the table above, Humana met all of the standards for seven of the eleven categories set forth in *42 CFR Part 438 Subpart D and the Quality Assessment and Performance Improvement (QAPI)*. Areas not meeting the standards included Coverage and Authorization of Services, Provider Selection, Grievances and Appeals, and Quality Assessment and Performance Improvement Program.

Table 2, Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the Readiness Review. For 2022, 174 out of 198 standards evaluated received a score of "Met." There were 16 standards scored as "Partially Met" and 8 standards related to credentialing, recredentialing, and corrections for previously identified deficiencies that received a "Not Met" score. There were 16 standards that CCME was unable to evaluate.

Table 2: Scoring Overview

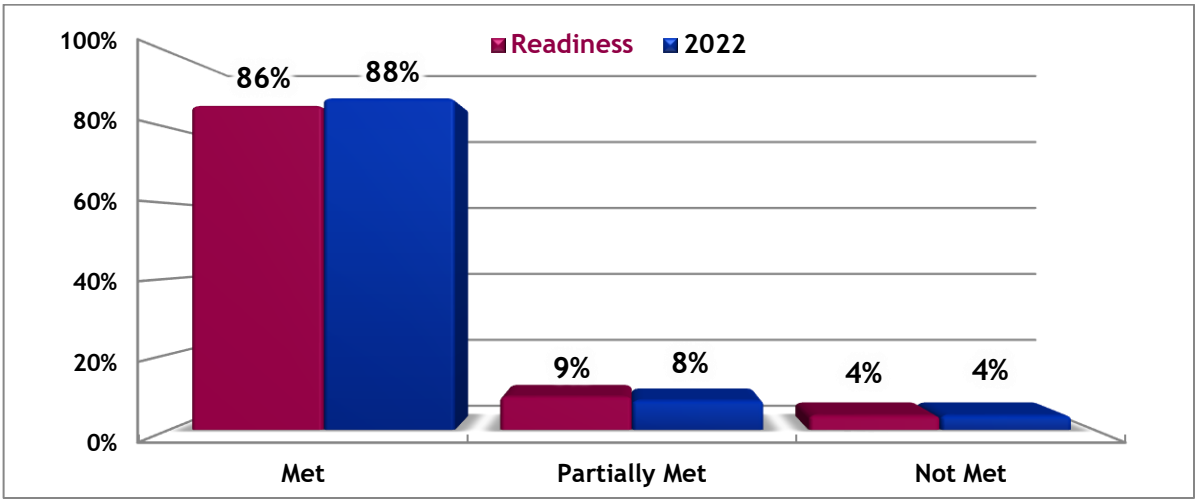
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
Readiness	32	1	7	0	0	40	80%
2022	38	2	0	0	0	40	95%

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Provider Services							
Readiness	68	5	2	0	0	75	91%
2022	64	6	5	1	0	76	85%
Member Services							
Readiness	29	3	0	0	0	32	91%
2022	21	1	0	11	0	33	95%
Quality Improvement							
Readiness	10	3	0	0	0	13	77%
2022	10	1	0	3	0	14	91%
Utilization Management							
Readiness	36	6	0	0	0	42	86%
2022	38	6	0	1	0	45	86%
Delegation							
Readiness	1	1	0	0	0	2	50%
2022	2	0	0	0	0	2	100%
State Mandated Services							
Readiness	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2022	1	0	3	0	0	4	25%
Totals							
Readiness	176	19	9	0	0	204	86%
2022	174	16	8	16	0	214	88%

**Percentage is calculated as: (Total Number of Met Standards / Total Number of Evaluated Standards) × 100. The Standards Not Evaluated were removed from the denominator and numerator.*

The 2022 Annual EQR shows that Humana achieved "Met" scores for 88% of the standards reviewed. As the following chart indicates, 8% of the standards were scored as "Partially Met," and 4% of the standards were scored as "Not Met." The chart that follows provides a comparison of the current review results to the Readiness Review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Assessment of Strengths and Weaknesses

The following is a summary of Humana's strengths, weaknesses, and recommendations or opportunities for improvement related to the quality, timeliness, and access to care identified during this annual review.

Table 3: Evaluation of Quality

Strengths Related to Quality
• Fraud, Waste, and Abuse training for staff are outlined in policies. • Humana focuses on data security, audits, assessments, and disaster recovery tests. • Training of staff is up to date on securely managing Humana's IT systems and data. • Humana has implemented a local Credentials Committee to comply with contractual requirements. • Onsite discussion highlighted several areas where edits and revisions had been made to the Member Handbook since the Readiness Review to increase overall quality. • The Quality Assurance Committee meeting minutes were very detailed and included extensive reports and discussions. • Care Management files reflect consistent evaluation of member needs, referrals to available community resources, and assistance with scheduling provider visits and transportation. Care plans address member needs appropriately. • Processes are in place to conduct pre-assessments of potential delegates' abilities to perform the selected delegated functions in compliance with contractual, regulatory, accreditation, and health plan standards and requirements. • Written delegation agreement and specify the activities delegated, the responsibilities for both the delegated entity and Humana, requirements for complying with Humana, state and federal law and accreditation organization requirements, processes for evaluating performance, and actions that may result of the delegate does not fulfill its obligations.

Strengths Related to Quality
• Ongoing delegate monitoring is conducted via annual audits, routine delegate reporting, and Joint Operations Committee meetings.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Policies were not consistently reviewed annually. • Multiple policies contain similar content with conflicting information.	• Quality Improvement Plan: Complete a comprehensive review of policies to reflect a current review cycle. Consolidate multiple existing policies with similar content.
• Compliance Committee minutes do not document quarterly meeting attendees, the establishment of a quorum, and motions and actions taken by the committee and subcommittees.	• Recommendation: Future Compliance Committee minutes record attendees, the establishment of a quorum, and track tasks completed by the committee and subcommittees.
• Policy (General Contractual Conditions Confidentiality Policy)-022, does not include steps and processes for assuring confidential information is safeguarded.	• Quality Improvement Plan: Review Policy (General Contractual Conditions Confidentiality Policy)-022, and include the steps and processes used to safeguard confidential information.
• The attendance documentation for the December 2021 South Carolina Medicaid Credentials Committee minutes listed two internal staff member attendees (with titles listed as a Credentialing Professional 2 and Credentialing Operations) in the "Voting Members" section. Onsite discussion confirmed this was incorrect and these staff members should have been included in the "Non-Voting Humana Staff" section of the minutes.	• Recommendation: Ensure non-voting members of the South Carolina Medicaid Credentials Committee are listed in the correct location of the minutes.
• The header of the December 2021 South Carolina Medicaid Credentials Committee minutes states, "Louisville Credentials Committee Agenda."	• Recommendation: Correct the heading of the minutes to reflect South Carolina instead of Louisville.
• Review of initial practitioner credentialing files revealed: o For 14 of 16 files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This is a repeated finding from the Readiness Review. o Two initial credentialing files for nurse practitioners were missing the full collaborative agreement between the nurse practitioner and the collaborating physician. Refer to the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8. This is a repeated finding from the Readiness Review. o None of the 16 initial credentialing provider files included evidence of querying the	• Quality Improvement Plan: o Ensure practitioner credentialing and recredentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. o Ensure credentialing and recredentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician. o Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at initial credentialing and recredentialing, and that all files include evidence of the query as well as the date of the query.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
SCDHHS SC Providers Terminated for Cause List. ○ Four files did not include evidence of the query of the Social Security Administration's Death Master File (SSDMF). Evidence of queries of the SSDMF was submitted after the onsite; however, the queries were conducted on March 3, 2022, and not prior to the initial credentialing determination for the four providers. • Review of practitioner recredentialing files revealed: ○ For 14 of 16 files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee approval date. This is a repeated finding from the Readiness Review. ○ Two recredentialing files for nurse practitioners were missing the full collaborative agreement between the nurse practitioner and the collaborating physician. This is a repeated finding from the Readiness Review. ○ None of the recredentialing provider files included evidence of querying the SC Providers Terminated for Cause List. ○ Six recredentialing files did not include evidence of the query of the SSDMF. Evidence of queries of the SSDMF was submitted after the onsite; however, the queries indicate they were conducted on March 3, 2022, and not prior to the recredentialing determination for the six providers.	○ Ensure all initial practitioner credentialing and recredentialing files include evidence of querying the Social Security Death Master File prior to the credentialing/recredentialing determination.
• Review of organizational provider initial credentialing and recredentialing files revealed the following issues: ○ For 12 initial credentialing files and 12 recredentialing files, the letter notifying the provider of the credentialing / recredentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review. ○ The query of the SCDHHS Excluded Provider's Report was conducted three months after the initial credentialing determination date for 1 file. ○ None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.	• Quality Improvement Plan: ○ Ensure organizational provider credentialing and recredentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. ○ Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every organizational provider at initial credentialing and recredentialing, and that the files include evidence of the query as well as the date of the query.
• Policy (Core Sanctions Policy)-002 describes ongoing monitoring for practitioner sanctions,	• Quality Improvement Plan: Revise Policy (Core Sanctions Policy)-002 to include the SCDHHS SC

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
exclusions, and debarments between recredentialing cycles. The policy states that at least every 30 days, credentialing staff review the South Carolina Excluded Providers list for newly excluded providers. However, the policy does not include that the SCDHHS SC Providers Terminated for Cause List is also monitored.	Provider Terminated for Cause List as a required monthly monitoring element.
• Non-functional hyperlinks were noted in the Provider Manual: ○ The link to the USDHHS Office of Minority Health (page 37) ○ The link to Humana's Cultural Competency Plan (page 44)	• Recommendation: In the Provider Manual, correct the hyperlink to the USDHHS Office of Minority Health on page 37 and the hyperlink to Humana's Cultural Competency Plan on page 44.
• Policy (On-line Provider Finder Tool and Hardcopy Directories) – 003 lists elements that must be included in the Provider Directory, but fails to include office hours, website URLs, and provider abilities to accommodate individuals with physical disabilities. All required elements were noted in both the print version of the Provider Directory and the online "Find a Doctor" tool.	• Recommendation: Revise Policy (On-line Provider Finder Tool and Hardcopy Directories) – 003 to include all elements that must be included in the Provider Directory. Refer to the *SCDHHS Contract, Section 3.13.5.1.1.*
• Policy and Procedure (Provider Training)-009 describes processes and topics for initial and ongoing provider education. Identified issues include: ○ Page 2, item #1 states, "If necessary to accommodate preferences of office staff, the below may be mailed." However, the policy does not list what may be mailed. ○ Page 3 of the policy lists materials that are available on the website. The list includes the "Louisiana Medicaid provider manual." This is an issue CCME noted during the 2021 Readiness Review and recommended that Humana correct. ○ The policy makes multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist. See item #2 on page two, item #4 on page three, and the "Attachments/Additional Resources" heading on page four. Humana confirmed that a New Provider Orientation Checklist and New Provider Orientation and Provider Training Checklist are not used.	• Quality Improvement Plan: Revise Policy (Provider Training)-009 to include items that may be mailed to providers (page two, item #1). Also, remove the reference to the Louisiana Medicaid provider manual (page 3) and remove references to the New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist (item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four).
• The Member Handbook does not include the limit on the number of chiropractic visits or information about communicable disease services, newborn hearing screenings, rehabilitative therapies for children, and transplant services are not included in the Member Handbook. Also, BabyNet Services are	• Recommendation: Revise the Member Handbook and include the limitation on the number of visits for chiropractic services and information about communicable disease services, newborn hearing screenings, rehabilitative therapies for children, and transplant services. Also include information about BabyNet services in the Member Handbook,

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
not included in the Member Handbook, Policy (UM-Core Benefits and Services)-007, or in the SC TANF CHIP Specific Core Benefits grid.	Policy (UM-Core Benefits and Services)-007, and in the SC TANF CHIP Specific Core Benefits grid.
• The 2012 and 2022 QI work plans were provided for review. There were several goals that have not been determined throughout the 2022 work plan.	• Recommendation: Determine the measurement goals for each activity on the 2022 work plan.
• The Quality Assurance Committee did not include a variety of participating network providers as required by the SCDHHS Contract, Section 15.3.1.2.	• Quality Improvement Plan: Recruit a variety of participating network providers as members of the Quality Assurance Committee.
• No performance improvement projects, or performance data was submitted for validation.	• Recommendation: Continue the review of baseline data and convene work groups so topics for performance improvement projects can be developed.
• There was not a specific policy or action steps planned for addressing the process for how the monitoring of over and underutilization will be conducted. This was an issue identified during the Readiness Review.	• Quality Improvement Plan: Provide more detail in the Utilization Management Data Plan regarding issues identified during the monitoring of over or underutilization. The data plan should include steps If monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.
• The UM Program Description discusses emergency services (page nine). However, does not include a description of post-stabilization services.	• Recommendation: Include a description of post stabilization services in the UM Program Description.
• The UM Program Description contained errors regarding the Medical Management and the Quality Assessment Committees.	• Recommendation: The UM Program Description should be updated to reflect the appropriate committee responsible for the oversight of the UM functions. Also, remove the references to the Quality Assessment and Performance Improvement Committee.
• Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provides a summary or the process used to manage the prior authorization list. Both policies contain basically the same information. Policy (Preauthorization List (PAL) Governance)-001 was watermarked draft and had an issue date of 2/25/2022. No explanation was provided regarding the purpose of both policies.	• Recommendation: Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 and determine which policy best defines the process Humana uses to manage the Preauthorization List.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• The Focus policy, Initial Case Review V 14.0, incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS MCO Policy and Procedure Guide, 4.2.24.*	• Quality Improvement Plan: Correct the timeframes for completing non-expedited reviews and include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse treatments in the Focus policy, Initial Case Review V 14.0.
• To date Humana has not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.	• Quality Improvement Plan: Conduct Inter-Rater Reliability testing for all staff who render clinical determinations.
• Notices for PDL changes found on Humana's website did not contain evidence that the change was posted at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*	• Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Humana's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*
• The Notice of Denial and the Notice of Partial Denial did not include information that standard appeal decisions can be extended by 14 days. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation for when to use this contact information.	• Quality Improvement Plan: Correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.
• Humana provided one appeal file. The resolution notice contained the following errors: ○ The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." ○ The language used to describe why the denial was upheld appeared to be above the 6th grade reading level.	• Quality Improvement Plan: Develop a process for monitoring resolution notices to ensure the letter contains correct reviewer information and the language meets the SCDHHS 6th reading level.
• The Care Management Program Description does not describe the structure of the Care Management Program.	• Recommendation: Revise the Care Management Program Description to include the program's structure, to include departmental oversight, leadership, staffing positions, etc.
• The Care Management Program Description does not provide detailed information about conducting satisfaction surveys with members who have been enrolled in the complex case management/disease management programs.	• Recommendation: Revise the Care Management Program Description to include detailed information about the processes for assessing member satisfaction specific to the Care Management Program. The information should include methods of survey, members who will be included, processes for conducting the survey, and

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
	processes for evaluating and reporting results of the survey.
• Column "BH" of the "Medicaid Reviews" tab of the Credentialing Annual Audit Tool contains both the SC Excluded Providers List and the SC Terminated for Cause List.	• Recommendation: List the SC Excluded Providers List and the SC Terminated for Cause List in separate columns on the "Medicaid Reviews" tab of the Credentialing Annual Audit Tool so that it is clear the delegates are querying both of these required lists.
• Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations.	• Quality Improvement Plan: Implement activities to track provider compliance with administering required immunizations.
• Humana presented no evidence that it is currently tracking provider compliance with performing EPSDT/Well Care services.	• Quality Improvement Plan: Develop a written policy and procedure for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible members.
• The SCDHHS Contract, Section 4.2.10.1 states MCOs must "Have written Policies and Procedures consistent with 42 CFR 441, Subpart B, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults."	• Quality Improvement Plan: Implement activities to track provider compliance with performing EPSDT/well care services for members.
• Humana did not implement all the Quality Improvement Plans from the 2021 Readiness Review to address the deficiencies identified during the 2021 Readiness Review.	• Quality Improvement Plan: Address and implement actions to correct all identified deficiencies.

Table 4: Evaluation of Timeliness

Strengths Related to Timeliness
• Humana provided detailed information during the onsite discussion about implemented ways to inform members timely of Preventive Health and Chronic Disease Management Education initiatives. • Review decisions were timely, and members were notified of these decisions appropriately.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
• Policy (SC Medicaid Network Availability and Access)-004 does not specify the frequency for conducting Mystery Shopper Surveys.	• Recommendation: Revise Policy (SC Medicaid Network Availability and Access)-004 to define the frequency for conducting Mystery Shopper Surveys.
• Policy (Medical Record Review)- 013 [HUM-SC-QM-006] does not define the frequency of the medical record reviews. Onsite discussion confirmed Humana will conduct MRR at least annually and more often if needed.	• Recommendation: Revise Policy (Medical Record Review)- 013 [HUM-SC-QM-006] to include the frequency of the provider medical record reviews.
Two of the seven grievance files submitted by Humana for review failed to meet Humana's policy	• Quality Improvement Plan: Review internal processes for meeting timeliness standards for

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
for timely acknowledgement. One file was noted as still in progress and should have been resolved by February 14, 2022 or an extension should have been requested. For one grievance, the resolution did not correlate to the member's grievance.	grievances and implement steps for performance improvements.

Table 5: Evaluation of Access to Care

Strengths Related to Access to Care
• The South Carolina Medicaid Network Adequacy Report allows the plan to display provider network detail by county, provider specialty type, the most recent evaluation results, and previous results. • Humana continues its efforts to close identified gaps in the provider network. • The Appeal, Complaint or Grievance Form on the Humana website is very user friendly, clear, and consistent with policies and processes to improve access to care. • Utilization Management files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination. • Humana covers all required core member benefits.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• The requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001.	• Quality Improvement Plan: Revise Policy (CORE Credentialing and Recredentialing)-001 to specify that querying the SCDHHS Termination for Cause List is a required element for initial credentialing and recredentialing for all practitioners and organizational providers.
• Information about member benefits is included in the Provider Manual; however, the following issues were identified: o Page nine states audiological services are covered but does not provide limitations to this coverage or indicate hearing aids for members 21 and over are not covered. See the SCDHHS Contract, Section 4.2.4. o Page nine states chiropractic services are covered and limited to manual manipulation of the spine to correct a subluxation. However, it does not include the limitation of six visits per year. See the SCDHHS Contract, Section 4.2.6. o Pages 28 states Humana uses the Universal BabyNet Prior Authorization Form but does not provide any information about the BabyNet program. See the SCDHHS Contract, Appendix E. o The Provider Manual does not indicate that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. See the SCDHHS Policy and Procedure	• Quality Improvement Plan: Revise the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
Guide for Managed Care Organizations, Section 4.2.18.	
• Policy (UM – Core Benefits and Services)-007 does not include newborn hearing screenings as a core benefit when rendered to newborns in an inpatient hospital setting.	• Quality Improvement Plan: Revise Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting.
• For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 55% of the time (84 out of 154) when omitting calls answered by personal or general voicemail messaging services. For calls not answered successfully (n = 70 calls), 36 (51%) were because the provider was no longer an active PCP at that location. • When asked if the provider accepts Humana, 70 of 84 providers (83%) confirmed that they do accept Humana. Of those 70, 49 providers (70%) confirmed they were accepting new Medicaid patients. • The access study also assesses routine appointment availability by asking "Is there a new patient appointment in the next 4 weeks for this provider?" For Humana, 11 of 49 providers who answered the question (22%) did not meet the requirement of a routine appointment within 4 weeks.	• Recommendation: Conduct routine outreach to all providers, particularly primary care providers, to verify demographic information and to re-educate staff on appointment standards and lines of business for network participation. Conduct additional internal audits to verify the accuracy of the provider file.

METHODOLOGY

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

On January 10, 2022, CCME sent notification to Humana that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow 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 from Humana on January 24, 2022 and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on March 2, 2022, and March 3, 2022. 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's administration and staff; and an exit conference. All interested parties were invited to the entrance and exit conferences.

FINDINGS

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

The administration review focuses on the health plan's policies and procedures, staffing, information systems, compliance, and confidentiality. Humana has developed policies and procedures to ensure adherence to the *SCDHHS Contract* and federal regulations.

Annual policy reviews are conducted at the department and management level. Staff have appropriate access to policies and are alerted to new policies and policy revisions by departmental leadership. The 2021 Readiness Review revealed policy issues, including policies that contained *SCDHHS Contract* references but lacked processes for meeting the contractual requirements, inclusion of information related to Medicare or other lines of business, and policies that were not specific to South Carolina. Humana addressed these issues. The table that follows provides an overview of the deficiencies and Humana's response.

Table 6: Readiness Review Deficiencies and Quality Improvement Response

Standard	EQR Comments
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.	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. *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.*
Humana Response: Humana reviewed policies and procedures to identify all documents that require updates in order to address the Readiness Quality Improvement Plan Review comments. Humana is currently updating identified documents to include the process for meeting the contractual requirements, specific to South Carolina Medicaid. Humana's plan and timeline for addressing the Review comments is as following: •Comprehensive review of policies and procedures – [COMPLETE] •Update policies and procedures to accurately reflect process (first draft) -June 10, 2021 •Finalize updated policies and procedures – July 1, 2021 •Comprehensive review of policy and procedure titling and formatting – ongoing	

The 2022 EQR found that policies and procedures are in place indicating that some of Humana's action steps in response to the Readiness Review finding were implemented. However, not at a comprehensive level. Many policies did not reflect consistent annual reviews by all departments. Some policies were last reviewed in 2020. A few examples include Policy (Continuity of Care)-010 last reviewed 11/5/2020, Policy (HPS Audit Discrepancy List Code)-001 last reviewed 11/5/2020, and Policy (Surveillance Policy)-

001A last reviewed 9/7/19. Clusters of policies not reviewed within the last twelve months were found for information, technology, and data systems policies.

During the Readiness Review, several key personal positions were vacant or in the recruitment process. Those vacant key positions are noted in *Table 7: Readiness Review Deficiencies and Quality Improvement Plans*.

Table 7: Readiness Review Deficiencies and Quality Improvement Plans

Standard	EQR Comments
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: 1.5.2 Utilization Review Staff	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.*
Humana Response: Lindsay Johnson, LCSW, and Karen Wisniewski, BSN, joined the Humana Healthy Horizons in South Carolina team on May 24th as our Behavioral Health and Physical Health Utilization Management team.	
1.5.3 *Case Management Staff	Humana is currently recruiting Case Management staff for SC. The Case Manager staffing ratio 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.*
Humana Response: LaToya Blackmon, LCWS, and Dana Eisenberg, RN, joined the Humana Healthy Horizons in South Carolina team on May 24th as our Behavioral Health and Physical Health Case Management team and their orientation will be completed prior to member enrollment.	
1.6 *Quality Improvement (Coordinator, Manager, Director);	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. *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.*
Humana Response: Dr. Ayo Gathing will start with Humana on June 1st as the Humana Healthy Horizons in South Carolina Medical Director. Dr. Gathing will assume the role of the Quality Improvement Manager until the plan reaches 90,000 members.	

Standard	EQR Comments
1.6.1 Quality Assessment and Performance Improvement Staff	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.*
Humana Response: Humana has posted its Quality Improvement position for Humana Healthy Horizons in South Carolina and is expecting to fill the role within 60-90 days.	
1.8 *Member Services Manager	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.*
Humana Response: Taffney Hooks, Member Services Manager and South Carolina resident, started with Humana Healthy Horizons in South Carolina on May 17th.	
1.9 *Medical Director	It was reported during the onsite discussion that Humana is currently recruiting, with an offer pending for a Medical Director. *Quality Improvement Plan: Develop a plan to ensure this position is filled before members are enrolled.*
Humana Response: Dr. Ayo Gathing will start with Humana Healthy Horizons in South Carolina on June 1st as our Medical Director. 6/8/21—At Humana we pride ourselves on having a Clinically Integrated Model of Care. This entails the provision of seamless, effective and efficient care that reflects the whole of a person's health needs: from prevention through treatment, across both physical and behavioral health, taking into consideration social determinants of health, and in partnership with the individual, their physician, family and community. Dr. Ayo Gathing is our SC Chief Medical Officer. She is a Board-Certified Psychiatrist with years of experience as a Medical Director. She supervises our Clinical Team comprised of a Health Services Director, UM/CM BH Clinicians, UM/CM Nurses, and a Transition Coordinator. Dr. Gathing will conduct our initial PA reviews in the market. We also have internal, Shared Services MD's licensed in SC that are available for consultation with Dr. Ayo, across multiple specialties. If necessary, we are also contracted with 2 vendors, FOCUS and NMR (Network Medical Review) who also have MD's licensed in SC across multiple specialties to support Dr. Gathing.	
1.13 Board Certified Psychiatrist or Psychologist	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.*
Humana Response: Dr. Ayo Gathing will start with Humana Healthy Horizons in South Carolina on June 1st as our board-certified psychiatrist.	

The current EQR found that previously identified vacant positions have been filled. The organizational chart demonstrates there is sufficient staff available to meet contract requirements. Policy (Humana Corporate Compliance Plan)-001C, outlines Humana's guidelines for a workplace climate in which ethics are integral to day-to-day operations. The Ethics Every Day document provides definitions of key ethical principles, examples of

potential violations, reporting processes, potential outcomes, and subsequent investigations.

Avenues for reporting suspected fraud, waste and/or abuse (FWA) are clearly defined on the Humana's website, in the Member Handbook, and in the Provider Manual. Telephonic, electronic, or mail options are provided. Multiple teams coordinate to identify and investigate suspected FWA referrals. Humana's code of conduct and Ethics Every Day document provide guidelines for FWA violations and sanctions. Internal monitoring and auditing are conducted to identify compliance risks. The Enterprise Investigations Consortium (EIC) conducts investigations for potential misconduct, FWA, criminal activity, and ethics and compliance concerns, including concerns received via the Ethics Help Line, to provide a basis for managing risk.

The Corporate Compliance Committee has been established to monitor significant issues, metrics, training, and adherence to compliance policies to ensure the program is effective. This committee is chaired by the CCO and is comprised of Humana's CEO, executive leaders, compliance officers, the Chief Audit Officer, and other senior leaders. The Committee meets on a quarterly basis, and more frequently as needed. Issues with wording in the frequency of committee meeting were identified and discussed onsite.

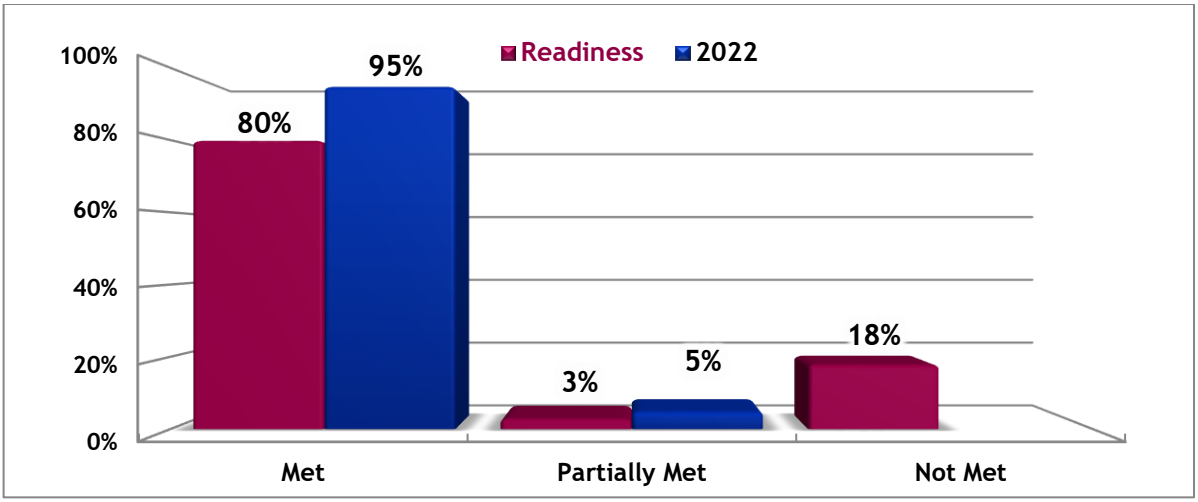
Annual trainings related to compliance and FWA are required for all staff, including the Chief Executive Officer, all senior leaders, the Board of Directors, and contingent labor.

Information Systems Capabilities Assessment (ISCA)

Humana's ISCA documentation indicates the MCO is capable of fulfilling the *SCDHHS Contract* requirements. Humana's policies and procedures align with industry best practices. In addition to sound IT policies, the organization has deployed monitoring tools to ensure IT systems function as designed and provide insight if there is an issue requiring investigation. Finally, Humana's staff receives IT training on a scheduled basis to ensure they are up to date on secure IT operations and data handling.

Humana demonstrated improvements in their staffing levels and filled many of the vacant positions as shown in the graphs that follow. *Figure 2: Administrative Findings* show 95% of the standards received a "Met" score for the 2022 EQR.

Figure 2: Administration Findings



Scores were rounded to the nearest whole number

Table 8: Administration Comparative Data

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
Organizational Chart / Staffing	Utilization Review Staff	Not Met	Met
	Case Management Staff	Not Met	Met
	Quality Improvement (Coordinator, Manager, Director)	Not Met	Met
	Quality Assessment and Performance Improvement Staff	Not Met	Met
	Member Services Manager	Not Met	Met
	Medical Director	Not Met	Met
	Board Certified Psychiatrist or Psychologist	Not Met	Met
Confidentiality	The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Partially Met

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

Strengths

- Fraud, Waste, and Abuse training for staff are outlined in policies.
- Humana focuses on data security, audits, assessments, and disaster recovery tests.
- Training of staff is up to date on securely managing Humana's IT systems and data.

Weaknesses

- Policies were not consistently reviewed annually.
- Multiple policies contain similar content with conflicting information.
- Compliance Committee minutes do not document meeting attendees, the establishment of a quorum, and actions taken by the committee and subcommittees.
- Policy (General Contractual Conditions Confidentiality Policy)-022, does not include steps and processes for assuring that confidential information is safeguarded.

Quality Improvement Plans

- Complete a comprehensive review of policies to reflect a current review cycle.
- Consolidate multiple existing policies with similar content.
- Review Policy (General Contractual Conditions Confidentiality Policy)-022, and include the steps and processes used to safeguard confidential information.

Recommendations

- Compliance Committee minutes should record meeting attendees, the establishment of a quorum, and track tasks completed by the committee and subcommittees.

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 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

Processes and requirements for initial credentialing and recredentialing of practitioners and organizational providers are found in the Credentialing & Recredentialing Program Description and in the enterprise-wide CORE Credentialing and Recredentialing (23rd ed)-001A policy. South Carolina-specific requirements are addressed in Policy (CORE Credentialing and Recredentialing)-001. These documents address the scope of

practitioners who must be credentialed, information to be collected and verified by the MCO, acceptable verification sources, the review and determination process, provider appeal rights, and requirements for non-discrimination against providers in high risk/high cost specialties. However, the South Carolina requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001 or in Policy (Core Sanctions Policy)-002. Humana corrected a deficiency identified during the 2021 Readiness Review regarding the requirement 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. See *Table 9: Readiness Review Provider Credentialing and Selection QIP Items* for details of the previously identified issue and Humana's response to the issue.

During the 2021 Readiness Review, it was noted that Humana did not have a local health plan Credentialing Committee, as required by the *SCDHHS Contract, Section 2.8*. (See *Table 9: Readiness Review Provider Credentialing and Selection QIP Items* below.*)* Instead, Humana's Corporate Credentials Committee was reviewing and making final credentialing determinations for the plan. To address this deficiency, Humana has now implemented the South Carolina Medicaid Credentials Committee, which began operations in December 2021. A committee charter has been established to define the purpose and structure of the committee, meeting frequency (monthly), and quorum (the presence of at least 75% of voting members). The Humana Medical Director chairs the committee, and membership includes actively practicing network practitioners with specialties of family practice, obstetrics and gynecology, psychiatry, a pharmacist, and a nurse practitioner.

Issues noted in the review of practitioner initial credentialing and recredentialing files included:

- Letters notifying the practitioner of the credentialing and recredentialing determination were dated prior to the credentialing committee approval date. This is a repeat finding from the Readiness Review.
- Files for nurse practitioners did not include the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. This is a repeat finding from the 2021 Readiness Review.
- None of the files included evidence of querying the SCDHHS SC Providers Terminated for Cause List.
- Several files did not include evidence of the query of the Social Security Administration's Death Master File (SSDMF).

Issues noted in the review of organizational provider initial credentialing and recredentialing files included:

- Letters notifying the providers of the credentialing and recredentialing determinations were dated prior to the credentialing committee approval date. This is a repeat finding from the Readiness Review.
- None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.
- The query of the SCDHHS Excluded Provider's Report was conducted three months after the determination date for one file.

As noted above, several of these findings were repeat findings from the 2021 Readiness Review for which Humana did not implement the Quality Improvement Plan. See *Table 9: Readiness Review Provider Credentialing and Selection QIP Items* for detailed information about the previous findings and Humana's response to those findings. Humana did, however, implement the Quality Improvement Plan for previously identified issues related to verification of Clinical Laboratory Improvement Amendment (CLIA) Certificates for providers billing laboratory procedures.

Table 9: Readiness Review Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	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.*
Humana Response: Humana revised its CORE Credentialing & Recredentialing Policy to define the process addressed in the Readiness Quality Improvement Plan comments for Line Item 9. Please refer to the following: • HUM4200-11132020 – Policy (CORE Credentialing and Recredentialing) – 001	
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the	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

Standard	EQR Comments
applicant. Such decisions, if delegated, may be overridden by the MCO.	South Carolina on this corporate committee. However, the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8* requires the following: •"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.*
Humana Response: Humana is actively in the process of standing up a local South Carolina Medicaid Credentials Committee, with a planned go-live date of July 2021. The South Carolina Medicaid Credentials Committee will be overseen by a South Carolina Humana Chief Medical Officer (CMO) and will be responsible for making determinations for all credentialing and recredentialing decisions. The South Carolina Medicaid Credentials Committee will meet monthly and will be comprised of participating providers from various specialties, including mid-level practitioners. Evidence of South Carolina Medicaid Credentials Committee discussion and decisions will be documented in meeting minutes and certified by the chairperson or designee by means of signature. Please refer to the following: •HM4200 -07012021 - Program Description (Credentialing Program Specific Description) •HM4200 -07012021 - Policy (Credentials Committee Program Specific Charter) •HM4200 -07012021-Policy (2021 Humana SC MCD QAPI Program Description)-012at pages 18-19, 26.	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	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.

Standard	EQR Comments
	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. *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. *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.*
Humana Response: Humana is implementing process updates to address the bulleted items. In addition, we are reviewing every credentialing file for the South Carolina Medicaid network and are in process of collecting any omitted information. 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. •HM4200 - 07012021 - Program Description (Credentialing Program Specific Description) – see section IV, page 4. In order to align the committee approval date, letter date and Medical Director approval date concerns raised, we plan to present all category 1 and category 2 providers to the monthly committee. The result will be the date on the letter is the same as the committee approval date.	

Standard	EQR Comments
Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician. •HM4200 - 11132020 – Policy (CORE Credentialing and Recredentialing)-001 – see page 7, first bullet The nurse practitioner requirements were updated in Humana's credentialing policy. If a nurse practitioner fails to provide a written collaborative agreement with a participating South Carolina Medicaid physician, the nurse practitioner will be terminated from the network. A written collaborative agreement is the only acceptable form of verification to satisfy this requirement.	
3.1 Verification of information on the applicant, including: 3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	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 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-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.*
Humana Response: Humana is implementing process updates to address the above item. In addition, we are reviewing every credentialing file for the South Carolina Medicaid network and are in process of collecting any omitted information. If a practitioner fails to provide evidence of CLIA when the application indicates labs are performed, the practitioner will be terminated from the South Carolina Medicaid network. A paper/digital/PDF copy of the site specific CLIA or verification via QCOR are the only acceptable form of verification to satisfy this requirement. Please refer to the following:	

Standard	EQR Comments
•HM4200 - 11132020 – Policy (CORE Credentialing and Recredentialing)-001, at page 5, last bullet for CLIA requirements •Verifying CLIA for Providers (Training documentation for associates)	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	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. •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 the 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.*
Humana Response: Humana is implementing process updates to address the above bulleted items. All Credentialing staff completed facility re-training and education on 05/06/2021. In addition, we are reviewing every facility credentialing file for the South Carolina Medicaid network and are in process of collecting any omitted information.	

Standard	EQR Comments
	the files include a signed statement that the information submitted is accurate to the best of the signee's knowledge. •Organizational Provider Credentialing Application – refer to page 6. •Credentialing applications are required as part of initial credentialing and recredentialing. Humana implemented a process change for South Carolina Medicaid to require formal facility assessment applications, including the attestation statement that information submitted is accurate to the best of the signee's knowledge. Humana's internal process guide for associates is being updated to reflect this change. the files include verification of liability insurance required by Humana. •HM4200 - 11132020 - Policy(CORE Credentialing and Recredentialing)-001 •Refer to page 6, last bullet for liability insurance requirement •Humana's internal process guide for associates is being updated to reflect this change. 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. •HM4200 - 07012021 - Program Description (Credentialing Program Specific Description) •In order to align the committee approval date, letter date and Medical Director approval date concerns raised by SCDHHS, we plan to present all cat 1 and cat 2 providers to the monthly committee. The result will be the date on the letter is the same as the committee approval date. CLIA verification is conducted prior to the credentialing determination. HM4200 - 11132020 - Policy(CORE Credentialing and Recredentialing)-001 Page 5, last bullet for CLIA requirements •CLIA Certification for Facility Credentialing and Recredentialing – Humana's internal process guide for associates.

Availability of Services

Established processes are in place for assessing and monitoring the adequacy of Humana's provider network. Network analysis is conducted at least every other week, with Geo Access mapping performed twice yearly and as needed. Humana staff reported that member-to-provider ratios are monitored at least biweekly, and provider panel status is monitored on an ongoing basis. Policy (SC Medicaid Network Availability and Access)-004 defines access standards for primary care providers (PCPs), required specialists, and hospitals that are compliant with contractual requirements.

The South Carolina Medicaid Network Adequacy Report, dated January 11, 2022, indicates goals were met for PCP access for all counties. For specialty providers, gaps were noted in a few counties, but Humana reported some of those gaps have been closed since the report was generated, and efforts continue to recruit providers to close the remaining gaps. For members affected by any current network gaps, Humana will execute

an agreement with out-of-network providers and authorize members to see those providers.

PCP and specialty appointment availability standards that comply with contractual requirements are documented in Policy (SC Medicaid Network Availability and Access)-004. The policy describes processes for monitoring and assessing provider compliance with appointment availability standards by using Consumer Assessment of Healthcare Providers and Systems (CAHPS) results, complaint and grievance data, requests for out of network provider agreements, and Mystery Shopper Survey results. The policy does not specify the frequency for conducting the Mystery Shopper Surveys, and onsite discussion revealed Humana plans to conduct the first Mystery Shopper Survey in July 2022.

Activities to ensure the provider network can meet members' cultural and other special needs include assessing membership ethnicity and racial diversity, educating staff about cultural competency and health literacy, making member materials available in appropriate formats and translations, utilizing telecommunications devices for the deaf and translator services, and providing cultural competency resources and training to providers.

Humana's print version of the Provider Directory and the online "Find a Doctor" tool include all required Provider Directory elements; however, Policy (On-line Provider Finder Tool and Hardcopy Directories) – 003, which lists elements that must be included in the Provider Directory, omits several required elements. The online "Find a Doctor" tool is available on the public-facing website, and printed copies of the Provider Directory are provided upon request.

Provider Access and Availability Study

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

As part of the annual EQR process for Humana, a provider access study focusing on primary care providers was performed by CCME. A list of current providers was given to CCME by Humana, from which a population of 2,170 unique PCPs was identified. A sample of 172 providers was randomly selected from the identified provider population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 55% of the time (84 out of 154) when omitting calls answered by personal or general voicemail messaging services (see Figure 3 below).

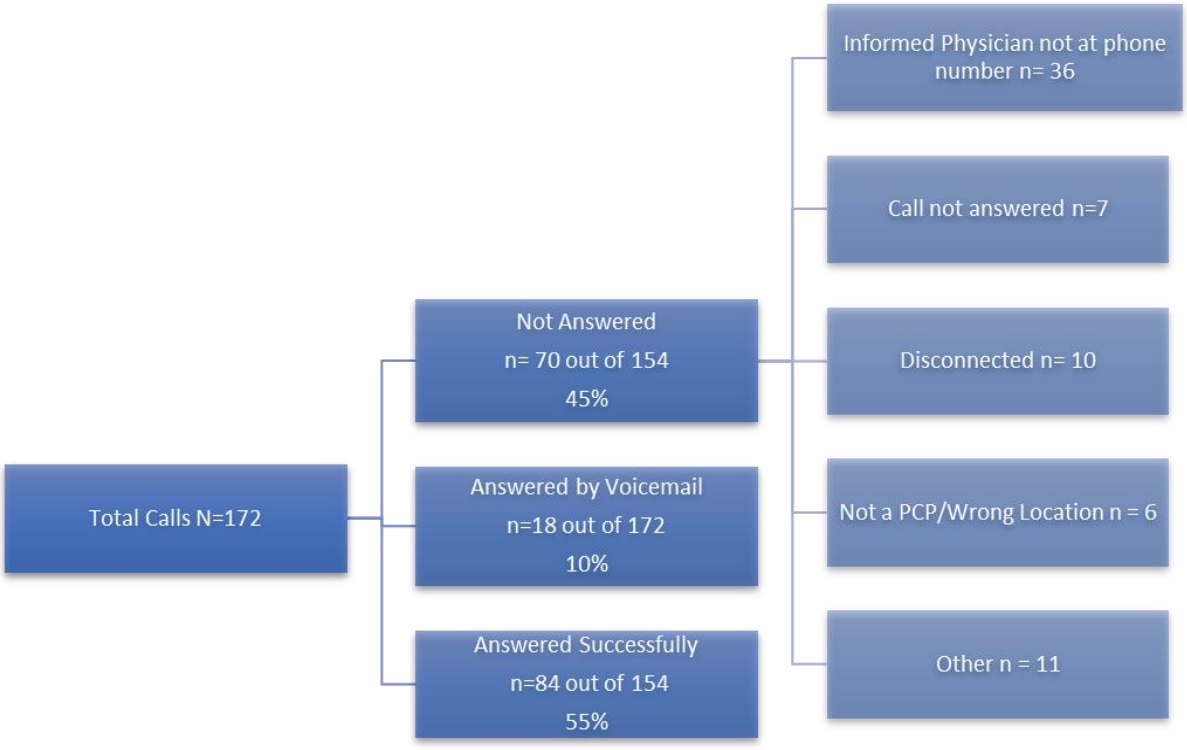
Table 10: Telephonic Access Study Answer Rate

Review Year	Sample Size	Answer Rate	p-value
2022	172	55%	N/A

For calls not answered successfully (n = 70 calls), 36 (51%) were because the provider was no longer an active PCP at the location. For the question "Do you accept Humana?" 70 of 84 providers (83%) confirmed that they do accept Humana. Of those 70, 49 providers (70%) confirmed they were accepting new Medicaid patients. Of the 49 providers, 14 (29%) indicated they do have prescreening requirements: one (7%) required an application, six (43%) required a medical record review, five (36%) required both, and two (14%) required vaccine records.

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

Figure 3: Telephonic Provider Access Study Results



The South Carolina provider access study also assesses routine appointment availability by asking the question "Is there a new patient appointment in the next 4 weeks for this

provider?" For Humana, 49 providers answered the question. Of the 49, 11 providers (22%) that did not meet the requirement of a routine appt within 4 weeks.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Processes for initial and ongoing provider education as well as topics covered during orientation and training sessions are detailed in Policy and Procedure (Provider Training)-009. Provider orientation is conducted within 30 days of a provider's contract effective date, and ongoing provider education training is conducted throughout the year. Several issues were noted in the Provider Training policy related to missing information, a reference to the Provider Manual for a health plan in a different state, and several references to a New Provider Orientation Checklist that Humana staff confirmed is not used.

The Provider Orientation and Training Slides document addresses covered services, member costs, EPSDT services, telehealth visits, pharmacy benefits, excluded services, and added benefits. The Provider Manual is a comprehensive resource for providers; however, information about covered benefits is incomplete. The Provider Manual does not include the limitations of coverage for audiological services and chiropractic services, fails to include information about coverage of newborn hearing screenings, and does not provide any information about BabyNet services.

Appropriate processes are in place for review and adoption of clinical practice guidelines (CPGs) and preventive health guidelines (PHGs). Approved guidelines are available to SC providers on Humana's website, and updates are announced in provider newsletters. Printed copies of the guidelines are provided upon request. The Provider Manual includes an overview of CPGs and PHGs and informs that provider compliance to the guidelines is monitored through claim, pharmacy, and utilization data.

A finding during the 2021 Readiness Review was that processes for monitoring coordination of care between providers was not identified in a program description or a policy. See *Table 11: Readiness Review Continuity of Care QIP Items.* The current review confirms that Policy (Coordination of Care) describes Humana's process for monitoring coordination of care between providers and includes methods of monitoring, assessment, and addressing identified deficiencies. To ensure appropriate coordination of care, Humana analyzes data between settings of care and for transitions of care from one provider to another. Reporting includes analysis of measures, identified barriers, and recommendations for improvement. The Quality Assurance Committee reviews the reporting and may approve the recommendations and offer additional recommendations.

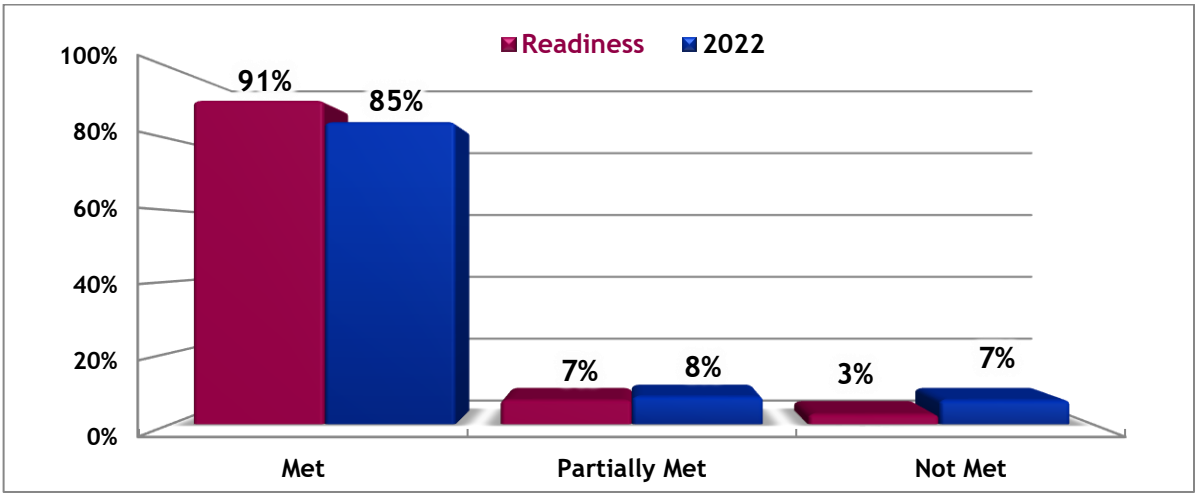
Table 11: Readiness Review Continuity of Care QIP Items

Standard	EQR Comments
II F. Continuity of Care	
1. The MCO monitors continuity and coordination of care between the PCPs and other providers.	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.*
Humana Response: Humana has documented its process for monitoring coordination of care between providers in its Continuity and Coordination of Care Policy and Medical Records Review Policy. As reflected in these policies, Humana collects and analyzes data reflecting member movement between providers, facilitating Humana's ability to ascertain whether PCPs are aware of such movement. These data sources include, for example, medical records identifying services provided through the MCO to include the name of the service providers, as well as documentation of emergency and after-hours encounters and follow up visits. Additionally, Humana analyzes data from various other sources, including but not limited to, provider and member survey feedback, HEDIS results, physician and facility correspondence, and disease and case management data. Humana utilizes the data to determine whether PCPs are aware of members receiving care elsewhere. If Humana's medical record review sampling process reveals that the provider failed to maintain appropriate records for the member, and thus is unaware of the member's movements between providers, then Humana undertakes additional steps to improve the PCP's compliance with the requirement for providers to maintain a comprehensive health record reflecting all aspects of care for the member. The Medical Record Review Policy also sets forth the actions that occur should a PCP score below the minimum threshold regarding records the provider maintains for the member, including, for example, additional investigation, corrective actions to be undertaken with the PCP, and consideration of same during the recredentialing process. Please refer to the following documents: • HUM4200 - 07012021 - Policy (Coordination of Care) • HUM4200 – 07212021-Policy (Medical Record Review)-013 at pages 2-3	

Medical record documentation standards and the provider medical record review (MRR) process are found in Policy (Medical Record Review) – 013. The policy defines the scoring goal and minimum threshold, and describes activities undertaken when physicians do not meet the threshold. However, the policy does not define the frequency of the MRRs. Onsite discussion confirmed Humana will conduct MRRs at least annually and more often if needed. Humana staff confirmed that an MRR was not conducted in 2021 but one is planned for Q2 or Q3 of 2022. Providers are informed of the medical record documentation standards in the Provider Manual. The Credentialing Department considers MRR results at provider recredentialing.

As noted in *Figure 4: Provider Services Findings*, 85% of the Provider Services standards were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding.

Table 12: Provider Services Comparative Data

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
Credentialing and Recredentialing	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	Met
	The credentialing process includes all elements required by the contract and by the MCO's internal policies	Partially Met	Not Met

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
Credentialing and Recredentialing	At initial credentialing, verification of information on the applicant, including: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Not Met
	Query of Social Security Administration's Death Master File (SSDMF)	Met	Partially Met
	Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Not Met	Met
	The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Not Met
	At recredentialing, verification of information on the applicant, including: Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Met	Not Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Met	Partially Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Partially Met	Not Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	Met	Partially Met
Provider Education	The MCO formulates and acts within policies and procedures related to initial education of providers.	Met	Partially Met
	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Partially Met

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
Continuity of Care	The MCO monitors continuity and coordination of care between PCPs and other providers	Partially Met	Met

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

Strengths

- Humana has implemented a local Credentials Committee to comply with contractual requirements.
- The South Carolina Medicaid Network Adequacy Report allows the plan to display provider network detail by county, provider specialty type, the most recent evaluation results, and previous results.
- Humana continues its efforts to close identified gaps in the provider network.

Weaknesses

- The requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001.
- The attendance documentation in the December 2021 South Carolina Medicaid Credentials Committee minutes listed two internal staff member attendees (with designations of "Credentialing Professional 2" and "Credentialing Operations") in the "Voting Members" section. Onsite discussion confirmed this was incorrect and these staff members should have been included in the "Non-Voting Humana Staff" section of the minutes. Also, the header of the December 2021 South Carolina Medicaid Credentials Committee minutes states, "Louisville Credentials Committee Agenda."
- Review of initial practitioner credentialing files revealed:
  - For 14 of 16 files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This is a repeated finding from the Readiness Review.
  - Two initial credentialing files for nurse practitioners were missing the full collaborative agreement between the nurse practitioner and the collaborating physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*. This is a repeated finding from the Readiness Review.
  - None of the 16 initial credentialing provider files included evidence of querying the SCDHHS SC Providers Terminated for Cause List.
  - Four files did not include evidence of the query of the Social Security Administration's Death Master File (SSDMF). Evidence of queries of the SSDMF was

submitted after the onsite; however, the queries were conducted on March 3, 2022, and not prior to the initial credentialing determination for the four providers.

- Review of practitioner recredentialing files revealed:
  - For 14 of 16 files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee approval date. This is a repeated finding from the Readiness Review.
  - Two recredentialing files for nurse practitioners were missing the full collaborative agreement between the nurse practitioner and the collaborating physician. This is a repeated finding from the Readiness Review.
  - None of the recredentialing provider files included evidence of querying the SC Providers Terminated for Cause List.
  - Six recredentialing files did not include evidence of the query of the SSDMF. Evidence of queries of the SSDMF was submitted after the onsite; however, the queries indicate they were conducted on March 3, 2022, and not prior to the recredentialing determination for the six providers.
- Review of organizational provider initial credentialing and recredentialing files revealed the following issues:
  - For 12 initial credentialing files and 12 recredentialing files, the letter notifying the provider of the credentialing/recredentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review.
  - The query of the SCDHHS Excluded Provider's Report was conducted three months after the initial credentialing determination date for 1 file.
  - None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.
- Policy (Core Sanctions Policy)-002 describes ongoing monitoring for practitioner sanctions, exclusions, and debarments between recredentialing cycles. The policy states that at least every 30 days, credentialing staff review the South Carolina Excluded Providers list for newly excluded providers. However, the policy does not include that the SCDHHS SC Providers Terminated for Cause List is also monitored.
- Non-functional hyperlinks were noted in the Provider Manual:
  - The link to the USDHHS Office of Minority Health, found on page 37 of the Provider Manual
  - The link to Humana's Cultural Competency Plan found on page 44 of the Provider Manual

- Policy (On-line Provider Finder Tool and Hardcopy Directories) – 003 lists elements that must be included in the Provider Directory, but fails to include office hours, website URLs, and provider abilities to accommodate individuals with physical disabilities. However, all required elements were noted in both the print version of the Provider Directory and the online "Find a Doctor" tool.
- Policy (SC Medicaid Network Availability and Access)-004 does not specify the frequency for conducting Mystery Shopper Surveys.
- For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 55% of the time (84 out of 154) when omitting calls answered by personal or general voicemail messaging services. When asked if the provider accepts Humana, 70 of 84 providers (83%) confirmed that they do accept Humana. The access study also assesses routine appointment availability by asking "Is there a new patient appointment in the next 4 weeks for this provider?" For Humana, 11 of 49 providers who answered the question (22%) did not meet the requirement of a routine appointment within 4 weeks.
- Policy and Procedure (Provider Training)-009 describes processes and topics for initial and ongoing provider education. Identified issues include:
    - Page 2, item #1 states, "If necessary to accommodate preferences of office staff, the below may be mailed." However, the policy does not list what may be mailed.
    - Page 3 of the policy lists materials that are available on the website. The list includes the "Louisiana Medicaid provider manual." This is an issue CCME noted during the 2021 Readiness Review and recommended that Humana correct.
    - The policy makes multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist. See item #2 on page two, item #4 on page three, and the "Attachments/Additional Resources" heading on page four. Humana confirmed that a New Provider Orientation Checklist and New Provider Orientation and Provider Training Checklist are not used.
- Information about member benefits is included in the Provider Manual; however, the following issues were identified:
    - Page nine states audiological services are covered but does not provide limitations to this coverage or indicate hearing aids for members 21 and over are not covered. See the *SCDHHS Contract, Section 4.2.4.*
    - Page nine states chiropractic services are covered and limited to manual manipulation of the spine to correct a subluxation. However, it does not include the limitation of six visits per year. See the *SCDHHS Contract, Section 4.2.6.*

  - Pages 28 states Humana uses the Universal BabyNet Prior Authorization Form but does not provide any information about the BabyNet program. See the *SCDHHS Contract, Appendix E*.
  - The Provider Manual does not indicate that newborn hearing *screenings are covered when rendered to newborns in an inpatient hospital setting. See the SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18.*
- Policy (UM – Core Benefits and Services)-007 does not include newborn hearing screenings as a core benefit when rendered to newborns in an inpatient hospital setting.
- Policy (Medical Record Review)- 013 [HUM-SC-QM-006] does not define the frequency of the medical record reviews. Onsite discussion confirmed Humana will conduct MRR at least annually and more often if needed.

Quality Improvement Plans

- Revise Policy (CORE Credentialing and Recredentialing)-001 to specify that querying the SCDHHS Termination for Cause List is a required element for initial credentialing and recredentialing for all practitioners and organizational providers.
- Ensure practitioner credentialing and recredentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.
- Include a copy of the current collaborative agreement between the nurse practitioner and the supervising physician in credentialing and recredentialing files for all nurse practitioners.
- Query the SCDHHS SC Providers Terminated for Cause List for every provider at initial credentialing and recredentialing. Include evidence of the query as well as the date of the query in all files.
- Query the Social Security Death Master File prior to the credentialing/recredentialing determination for all practitioners and include evidence of the query and the date of the query in all files.
- Ensure organizational provider credentialing and recredentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee.
- Query the SCDHHS SC Providers Terminated for Cause List for every organizational provider at initial credentialing and recredentialing. Include evidence of the query as well as the date of the query in all files.
- Revise Policy (Core Sanctions Policy)-002 to include the SCDHHS SC Provider Terminated for Cause List as a required monthly monitoring element.

- Revise Policy (Provider Training)-009 to include items that may be mailed to providers (page two, item #1). Also, remove the reference to the Louisiana Medicaid provider manual (page 3) and remove references to the New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist (item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four).

- Revise the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting.

- Revise Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting.

Recommendations

- Ensure non-voting members of the South Carolina Medicaid Credentials Committee are listed in the correct location of the minutes. Correct the heading of the minutes to reflect South Carolina instead of Louisville.
- In the Provider Manual, correct the hyperlink to the USDHHS Office of Minority Health on page 37 and the hyperlink to Humana's Cultural Competency Plan on page 44.
- Revise Policy (On-line Provider Finder Tool and Hardcopy Directories) – 003 to include all elements that must be included in the Provider Directory. Refer to the *SCDHHS Contract, Section 3.13.5.1.1.*
- Revise Policy (SC Medicaid Network Availability and Access)-004 to define the frequency for conducting Mystery Shopper Surveys.
- Conduct routine outreach to all providers, particularly primary care providers, to verify demographic information and to re-educate staff on appointment standards and lines of business for network participation. Conduct additional internal audits to verify the accuracy of the provider file.
- Revise Policy (Medical Record Review)- 013 [HUM-SC-QM-006] to include the frequency of the provider medical record reviews.

C. Member Services

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

The review of Member Services included policies and procedures, member rights, member materials, and the handling of grievances, disenrollment, and practitioner changes.

Humana's members have access to Member Services staff from 8:00 a.m. until 8:00 p.m. Monday through Friday, and the Nurse Help Line is available 24 hours a day. Member Services staff are available via a toll-free number or TTY service.

Humana has policies and documentation that detail member rights and responsibilities. This information is outlined consistently in the member Welcome Packet, the Member Handbook, the Humana website, and in Policy (Member Rights)-028.

As outlined in the Member Handbook, Welcome Packets are provided to members within 15 days. Policy (MARKETING)-001 Marketing and Member Communication and Policy (Enrollee ID Card Requirements)-001 describe documents included in the new member Welcome Packet. New members receive an introduction letter, a Plan Booklet providing an overview of benefits and services, member rights and responsibilities, 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.

Benefits offered by Humana well as SCDHHS benefits are covered in the Member Handbook, including information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. According to the Member Handbook, Policy (Marketing)-01, and Policy (UM-Core Benefits and Services)-007, members are informed in writing within 30 days of the effective date if there are any changes in benefits. During the 2021 Readiness Review, issues were noted regarding lack of information in the Member Handbook about notification of benefit changes and about EPSDT services. Humana revised the Member Handbook and policies to address these deficiencies. A summary of those issues is included in *Table 13: Readiness Review Member Education QIP Items*.

Table 13: Readiness Review Member Education QIP Items

Standard	EQR Comments
III B. Member MCO Program Education	
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including: 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 informed of benefit changes in*

Standard	EQR Comments
	writing 30 days before the effective date as required by the SCDHHS Contract, Section 3.13.
Humana Response: Please refer to SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 page 46.	
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 recommended schedule for members to obtain age-appropriate services.*
Humana Response: Please refer to SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 at page 50 - 52.	
3. Members are informed in writing of changes in benefits and changes to the provider network.	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.*
Humana Response: Humana has updated its Marketing and Member Communication Policy, as well as its Core Benefits & Services Policy to include the process for informing members in writing of changes in benefits. Please refer to the following redlined documents: • HM4200 - 11162020- Policy (MARKETING)-001 at page 8 • HM4200 - 07012021 - Policy(UM- Core Benefits and Services)-007 at page 20 6/9 - For line 18, we revised and submitted the UM Core Benefits Policy and updated the QIP tool / chart response 6/11 – See additional information uploaded.	

Policy (UM- Core Benefits and Services)-007 indicates Humana includes benefit information in the Member Handbook. However, the Member Handbook does not include the limit on the number of chiropractic visits or information about communicable disease

services, newborn hearing screenings, rehabilitative therapies for children, and transplant services. Also, BabyNet Services are not included in the Member Handbook, Policy (UM-Core Benefits and Services)-007, or in the SC TANF CHIP Specific Core Benefits grid.

Annually, Humana conducts a Member Satisfaction Survey. Humana has contracted with SHP Analytics to conduct the CAHPS Survey for the Adult, Child, and Child with Chronic Conditions populations. SHP Analytics is on track for reporting the results in June/July 2022. Therefore, the Validation of the Member Satisfaction Survey was not conducted for this EQR. Humana also mentioned the timeline for administering the ECHO survey is scheduled to start in March 2023.

Grievances

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

Humana has policies and procedures that describe the process for receiving and responding to member grievances. During the Readiness Review deficiencies were identified with Humana's grievance policies. Humana implemented a Quality Improvement Plan to address these deficiencies, as noted in *Table 14: Readiness Review Grievances Deficiencies and QIP Responses*. For this EQR, CCME found all deficiencies had been corrected.

Table 14: Readiness Review Grievances Deficiencies and QIP Responses

Standard	EQR Comments
III F. Grievances	
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: 1.2 Procedures for filing and handling a grievance;	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	EQR Comments
	•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.* *•Correct the grievance phone number listed in the Member Handbook, page 26.*
Humana Response: Humana has incorporated the referenced revisions. Please see the following: • HM4200 – 07012021 – Policy(South Carolina Medicaid Grievance First Level Review) – 001F at page 2 • HM4200 – 07012021 – Policy(South Carolina Medicaid Expedited Grievance First Level Review) – 001C • HM4200 – 07012021 – Policy(South Carolina Medicaid Grievance and Appeal Policy)-001 at page 4 • SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 at page 27 6/9 - For Line 19, we updated the QIP tool/response but did not submit any additional documents. All additional information we added to the QIP tool / chart is highlighted in yellow. Humana has incorporated the referenced revisions. Please see the following: • HM4200 – 07012021 – Policy(South Carolina Medicaid Grievance First Level Review) – 001F at page 2 • HM420– 07012021 – Policy(South Carolina Medicaid Expedited Grievance First Level Review) – 001C • HM4200 – 07012021 – Policy(South Carolina Medicaid Grievance and Appeal Policy)-001 at page 4 (last sentence of paragraph addressing 9.1.4.2) • SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean_4802 at page 27	

The Grievance process is outlined in Policy (Grievance and Appeals)-011 and on the Humana website. Members and their representatives are informed of the right to file a grievance at any time. The term "grievance" is consistently defined in Policy (Grievance and Appeals)-011, the Humana website, in the Member Handbook, and in the Provider Manual. Timelines are clearly outlined in policy (South Carolina Grievance First Level Review)-001F, and Humana's website has a link to the Appeal, Complaint or Grievance Form. Grievances are acknowledged within five business days with resolution to be

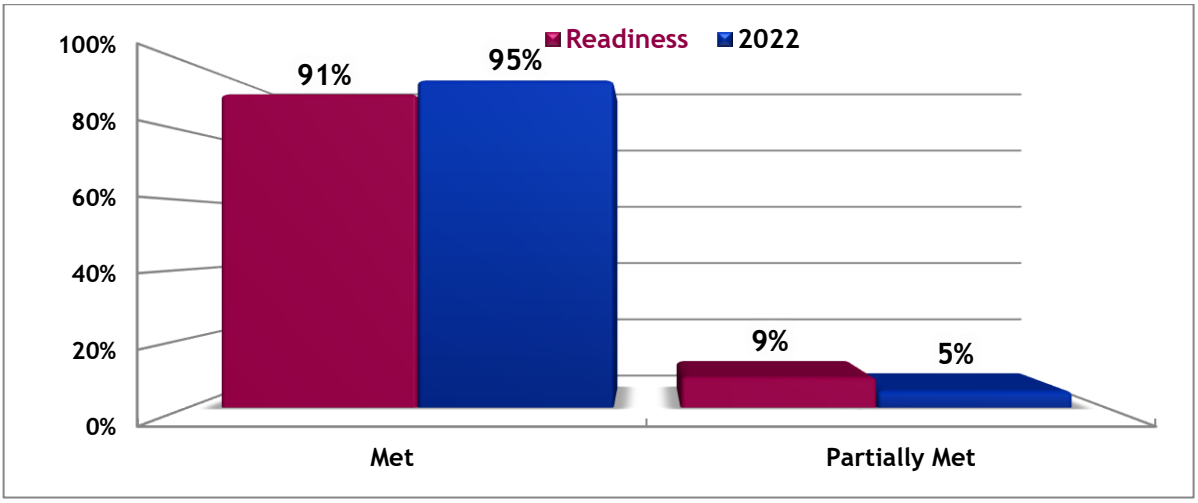
completed within 90 calendar days. Grievances are logged, categorized, analyzed, and reported internally per policy and contractual requirements.

Humana submitted seven grievance files for review. Concerns were identified in four of the seven files:

- There were two files that did not meet Humana's timeliness policy for sending an acknowledgement letter.
- One file was noted as still in progress. This grievance related to a member being unable to locate her PCP was received on November 16, 2021 and should have been resolved by February 14, 2022. During the onsite, Humana indicated this case has since been resolved and the resolution letter dated February 14, 2022 was provided. There were no notes included in the file to indicate there was a delay in resolving this grievance. CCME was concerned due to the length of time it took for resolution and the lack of notes in the file.
- In another file, the member's complaint was that she was unable to locate a PCP in her area and she requested a list of PCPs. Humana attempted to reach the member by phone without success. Humana sent the member resolution letter 10 days after receipt without providing the member with a list of PCPs. The letter only documented the attempts to reach the member.

As noted in *Figure 5: Member Services Findings*, Humana received a "Met" score for 95% of the Member Services standards that were evaluated. There were 11 standards related to the Member Satisfaction Survey that were not evaluated.

Figure 5: Member Services Findings



Percentages may not total 100% due to rounding.

Table 15: Member Services Comparative Data

SECTION	STANDARD	READINESS REIVEW	2022 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	Met
	Members are informed in writing of changes in benefits and changes to the provider network	Partially Met	Met
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	Met
	The MCO applies grievance policies and procedures as formulated	N/A	Partially Met

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

Strengths

- Onsite discussion highlighted several areas where improvements had been made to the Member Handbook since the Readiness Review to increase overall quality.
- Humana provided detailed information during the onsite discussion about implemented ways to inform members timely of preventive health and chronic disease management education initiatives.
- The Appeal, Complaint or Grievance Form on the Humana website is user-friendly, clear, and consistent with policies and processes to improve access to care.

Weaknesses

- The Member Handbook does not include the limit on the number of chiropractic visits or information about communicable disease services, newborn hearing screenings, rehabilitative therapies for children, and transplant services. Also, BabyNet Services

are not included in the Member Handbook, Policy (UM-Core Benefits and Services)-007, or in the SC TANF CHIP Specific Core Benefits grid.

- Two of the seven grievance files submitted by Humana for review failed to meet Humana's policy for timely acknowledgement. One file was noted as still in progress and should have been resolved by February 14, 2022 or an extension should have been requested. For one grievance, the resolution did not correlate to the member's grievance.

Quality Improvement Plans

- Review internal processes for meeting timeliness standards for grievances and implement steps for performance improvements.

Recommendations

- Revise the Member Handbook and include the limitation on the number of visits for chiropractic services and information about communicable disease services, newborn hearing screenings, rehabilitative therapies for children, and transplant services. Also include information about BabyNet services in the Member Handbook, Policy (UM-Core Benefits and Services)-007, and in the SC TANF CHIP Specific Core Benefits grid.

D. Quality Improvement

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

Humana has a Quality Improvement (QI) program designed to monitor, evaluate, and improve the quality of care and services provided. The 2021 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description was submitted for review. The scope of work in the program description includes areas such as preventive health, quality of services, over and underutilization, population health management, behavioral health, continuity and coordination of care, accessibility and availability of care, member and provider satisfaction and health outcomes. During the Readiness Review, it was noted that the program description did not include the scope of work. Humana corrected this deficiency. The following table provides an overview of the deficiency and Humana's response.

Table 16: Readiness Review Quality Improvement Program Deficiency and QIP Response

Standard	EQR Comments
IV A. The Quality Improvement (QI) Program	
1. The MCO has a system in place for implementing a formal quality improvement program with clearly defined goals, structure, scope and	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:

Standard	EQR Comments
methodology directed at improving the quality of health care delivered to members.	developing clinical strategies and programs 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.*
Humana Response: Humana has updated Section E of the QI Program Description to address the scope of the program. Please refer to the following document: HM4200 - 07012021 – Policy (2021 Humana SC MCD QAPI Program Description)-012 at page 8.	

On an annual basis, the Quality Department reviews and revises, as needed, the Quality Program Description.

Humana develops an annual work plan that specifies activities planned to assess the quality and appropriateness of care furnished to members. The work plan is updated as needed and approved annually by the Quality Assurance Committee. The 2021 and 2022 QI Work Plans were provided for review. There were several goals that have not been determined throughout the 2022 Work Plan.

Humana's Quality Assurance Committee (QAC) is responsible for directing and reviewing quality improvement activities and taking appropriate actions as needed. Pages 15 - 25 of the QI Program Description includes the Quality Committee Structure and a description of each committee. The Pharmacy and Therapeutics Committee is not included In the chart on page 15, and a description of the Health Services Organization National UM Committee was not included in the program description. This was a recommendation from the Readiness Review that was not corrected. Humana's staff indicated during the onsite this had been corrected in the 2022 QI Program Description. The 2022 QI Program Description was provided following the onsite and corrections were made.

Humana's Medical Director serves as Chair for the QAC. Members of the committee include senior staff department leads, directors, and managers. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. However, the membership list and committee minutes for this committee did not include any participating network practitioners. Humana indicated recruitment efforts are underway to recruit providers.

The QAC meets at least quarterly, and a quorum has been defined as 50% of the voting members plus one. Voting members are expected to attend each meeting; in their absence proxy representation is required. Committee minutes for meetings held in September 2021, November 2021, and February 2022 were provided. The minutes were very detailed and included extensive reports and discussions.

Humana uses the Stars Quality Report, which provides a list of members that have a known gap in care. The Stars Quality Report is delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax. Policy (NNO 702-040 Physician Performance Measurement) – 007 and Policy (NNO 702-040-11 Physician Performance Measurement) outline the process used to evaluate providers' performance. This policy was updated following the Readiness Review. The table that follows provides an overview of the deficiency and Humana's response.

Table 17: Readiness Review Deficiency and Humana's Response

Standard	EQR Comments
IV E. Provider Participation in Quality Improvement Activities	
2. Providers will receive interpretation of their QI performance data and feedback regarding QI activities.	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 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.*
Humana Response: Humana updated the referenced policy to include the specific procedure for monitoring for SC providers performance (refer to redlined updates in HM4200 - 07012021 - Policy (NNO 702-040 Physician Performance Measurement)-007). In addition, Humana updated the supporting enterprise policy to indicate applicability to Medicaid (refer to HM4200 - 08122010 - Policy (NNO 702-040 Physician Performance Measurement) 007A– page 1). In addition to the Physician Performance Measurement documents, please refer to HUM4200 – 07212021-Policy (Medical Record Review)-013 and HM4200 - 05162013- Policy (Guidelines for Eval Clinical Practice Guidelines Adherence)-010B for details regarding to other provider monitoring processes.	

Humana evaluates the effectiveness of the QI program and activities conducted in the previous year. Per Humana, with 2021/2022 being the first calendar year of operations, the QI program evaluation is scheduled to be completed in August 2022. The evaluation will address the accomplishments, analyze data and outcomes compared to goals, and include limitations or barriers to meet objectives. The program evaluation will be reviewed and approved by the Quality Assessment Committee and provided to Humana's internal board.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Humana did not provide performance measures for validation. Per onsite discussion, Humana expects to have reported rates next year.

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

There were no projects submitted for validation. Per onsite discussion, the health plan is reviewing baseline data, other data sources, and forming work groups to begin discussions regarding topics for performance improvement projects. 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 consider the prevalence of a condition in the member population. As a result of a previous deficiency (see *Table 18: Readiness Review Deficiency and Humana's Response*), this policy was updated 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.

Table 18: Readiness Review Deficiency and Humana's Response

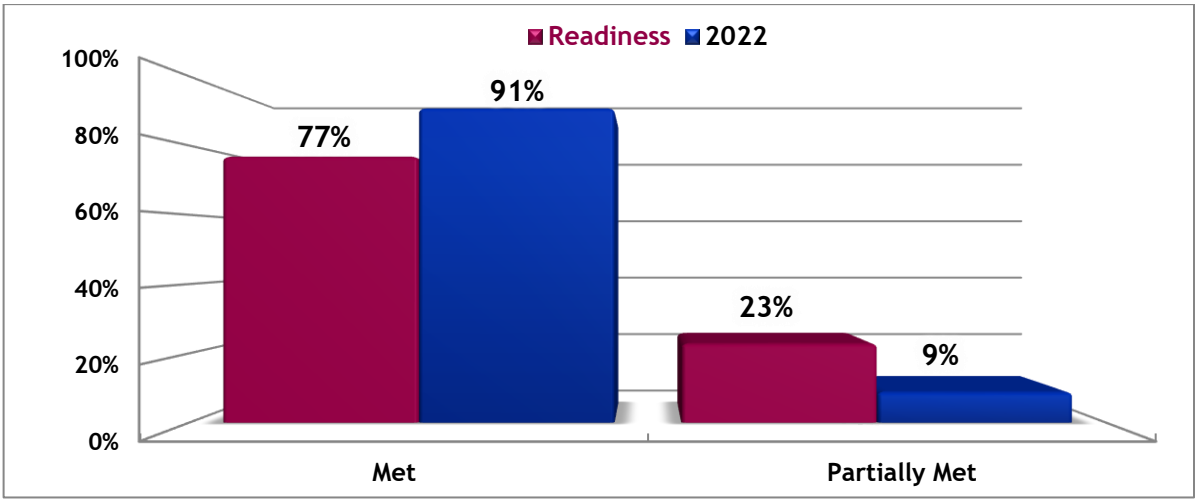
Standard	EQR Comments
IV D. Quality Improvement Projects	
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	Per policy (PIP) HUM-SC-MCD-QM-002-01, the Quality Director will work with Medicaid and Quality Improvement leadership 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. *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.*

Standard	EQR Comments
Humana Response: Humana has updated its HUM-SC-MCD-QM-002-01 policy, "Performance Improvement Projects," to add details regarding the development and selection of performance improvement project topics, data sources, and approval steps. Please refer to the following document: HM4200 - 07012021 - Policy (Performance Improvement Projects)-004	

Humana submitted the template they plan to use to document performance improvement projects. The template included all required elements.

Humana met 91% of the standards evaluated in the Quality Improvement section; 5% received a "Partially Met" score as noted in *Figure 6*. There were three standards (21%) related to the performance measures and performance improvement projects that could not be evaluated during this EQR.

Figure 6: Quality Improvement Findings



Percentages may not total 100% due to rounding.

Table 19: Quality Improvement Comparative Data

SECTION	STANDARD	READINESS REVIEW	2022
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	Met

SECTION	STANDARD	READINESS REVIEW	2022
The Quality Improvement (QI) Program	The composition of the QI Committee reflects the membership required by the contract.	Met	Partially Met
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	N/A	Not Evaluated
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	Not Evaluated
Provider Participation in Quality Improvement Activities	Providers will receive interpretation of their QI performance data and feedback regarding QI activities	Partially Met	Met

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

Strengths

- The Quality Assurance Committee meeting minutes were very detailed and included extensive reports and discussions.

Weaknesses

- The 2021 and 2022 QI Work Plans were provided for review. There were several goals that have not been determined throughout the 2022 Work Plan.
- The Quality Assurance Committee did not include a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*.
- No performance improvement projects or performance data were submitted for validation.

Quality Improvement Plans

- Recruit a variety of participating network providers as members of the Quality Assurance Committee.

Recommendations:

- Determine the measurement goals for each activity on the 2022 Work Plan.
- Continue the review of baseline data and convene work groups so topics for performance improvement projects can be developed.

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)

Humana has developed a program description and several policies and documents that guide staff in the implementation of utilization management functions. The Utilization Management Program Description 2021 describes and defines Humana's Utilization Management (UM) service areas, such as service authorizations, pharmacy, care management, appeals, and grievances. The daily oversight and operating authority of UM activities is delegated to the Medical Management Committee. Page seven of the UM Program Description provides an overview of the responsibilities and requirements for this committee. Humana indicated due to limited data and medical monitoring metrics discussed in other meetings and committees, this committee was dismantled, and the responsibilities of the Medical Management Committee were transferred to the Quality Assessment Committee. It was recommended that the UM Program Description should be updated to reflect the appropriate committee responsible for the oversight of the UM functions. Other issues with the UM Program Description included:

- Page five incorrectly references the Plan Quality Assessment and Performance Improvement Committee. Humana does not have a committee titled "Quality Assessment and Performance Improvement Committee."
- Page 13 discusses emergency care but fails to mention coverage for post stabilization care.

Humana's Medical Director oversees all aspects of the UM Program. A registered pharmacist oversees the implementation, monitoring and directing of pharmacy services.

Humana has developed a list of services that require prior authorization, and the website provides multiple resources and links for providers regarding the prior authorization process and services that require authorization. Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provide a summary of the process used to manage the prior authorization list. Both policies contain basically the same information. Policy (Preauthorization List (PAL) Governance)-001 was watermarked "draft" and had an issue date of 02/25/2022. No explanation was provided regarding the purpose of both policies.

Medicaid Coverage Policies, MCG, and American Society of Addiction Medicine (ASAM) are the criteria used for the initial review of authorization requests. The timeliness for Utilization Management decisions is included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Requests for non-urgent standard authorizations are reviewed within 14 calendar days following receipt of the request for authorization. Urgent authorization requests are reviewed within 72 hours after receipt of the request. The review of approval and denial files confirms Humana performs reviews using appropriate criteria with notification promptly communicated to the provider and member, as applicable. Focus Health, Inc. provides Behavioral Health Utilization Management Reviews. The Focus policy, Initial Case Review V 14.0, contained the timeframes for completing requests for peer reviews. This policy incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.24*.

Humana's UM Program Description and Policy, Utilization Management Inter-Rater Reliability, provided a summary of the Inter-Rater Reliability (IRR) monitoring process used to assess consistent decision-making for all staff who render clinical determinations. The goal is an overall average score of 85% for physicians and 90% for non-physician reviewers. To date Humana has not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.

Hysterectomies, sterilizations, and abortions are mentioned in the Member Handbook and Provider Manual as covered benefits. Providers are instructed via the Provider Manual of the requirements and consent forms needed for hysterectomies, sterilizations, and abortions. During the Readiness Review, CCME found the information regarding the specific requirements for covering hysterectomies, sterilizations, and abortions was not included in the Provider Manual and Member Handbook. Also, Humana did not have a policy or process for how hysterectomies, sterilizations, and abortions would be handled by the health plan. Humana addressed this deficiency and CCME found the corrections were made. The table that follows provides an overview of this deficiency and Humana's response.

Table 20: Readiness Review Medical Necessity Determinations QIP

Standard	EQR Comments
V B. Medical Necessity Determinations	

Standard	EQR Comments
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	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.*
Humana Response: Humana updated its Member Handbook and Provider Manual to provide additional detail regarding the requirements of Section 4 of the SCDHHS Policy and Procedure Guide regarding hysterectomies, sterilizations, and abortions. Additionally, Humana revised its Core Benefit Policy to address the process for handling hysterectomies, sterilizations, and abortions. Please refer to the following: • SC_TANF_EnrolleeHandbook_SCHL2L4EN at page 42 • Final HHH in SC Provider Manual at pages 9-10 • HM4200 – 07012021 – Program Description (Utilization Management)-006 at page 12 • SC TANF CHIP Specific Core Benefit Policy at pages 1, 7, 14	

Humana provided several letter templates for notifying providers and members of adverse benefit determinations. The Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days when requested by the member or by the plan. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation to the member for when to use this contact information.

The review of approval and denial files confirms Humana performs reviews using appropriate criteria with notification promptly communicated to provider and member, as applicable. UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.

The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List (PDL) changes on their websites at least 30 days prior to implementation. Policy (Formulary Change Notification Process)-005, defines how Humana notifies affected parties of changes to the formulary. Notices for PDL changes were found on Humana's website; however, the effective date for the change and when the notice was published to the website were not clear. The notice contained a date at the top of the page without an explanation of what this date represents.

Appeals

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

Humana has several policies that describe appeals. Policy (South Carolina Medicaid Grievance and Appeal Policy) – 001 and policy (South Carolina Medicaid Grievance and Appeal Policy Draft)-001E only included the *SCDHHS Contract* references and did not specify Humana's process for handling appeals. The process for handling appeals is contained in Policy (South Carolina Medicaid Standard Appeal First Lever) – 001G, Policy (South Carolina Medicaid Expedited Appeal First Level) – 001B, and Policy (South Carolina Medicaid Fair Hearing External Second Level Review)-001D. Information on the appeal process was also found in the Member Handbook, the Provider Manual, and on Humana's website. Humana resolves and provides resolution within 30 calendar days of receipt for standard appeals and within 72 hours of receipt for expedited appeals, as noted in policies. If a request for expedited appeal is denied, the member is notified, and the appeal is processed within the standard 30-day timeframe. During the Readiness Review there were several issues identified in Humana's policies and other documents regarding the definition of an appeal, the procedures for filing an appeal, and the timeliness guidelines for resolution. A review of the policies and other documents found those issues were corrected. The following table provides an overview of those issues and Humana's response.

Table 21: Readiness Review Appeals QIP

Standard	EQR Comments
V C. Appeals	
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: 1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	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. •Policy (South Carolina Medicaid Standard Appeal First Level)-001G refers to Kentucky Medicaid on the top of page three for definitions.

Standard	EQR Comments
	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.
Humana Response: Humana has updated the SC Medicaid Member Handbook to include definitions of "appeal" and "adverse benefit determination." Humana removed the reference to Kentucky Medicaid from the Standard Appeal First Level policy. (Humana reviewed the SC Medicaid Grievance and Appeal Policy but found no reference to Kentucky in that document.) Please refer to the following: • SC_TANF_EnrolleeHandbook_SCHL2L4EN_Clean at pages 10 & 56 • HM4200 – 07012021 – Policy(South Caroline Medicaid Standard Appeal First Level)-001G at page 3	
1.2 The procedure for filing an appeal;	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. 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

Standard	EQR Comments
	Appeal First Level-001B, the Provider Manual, and the Appeal Acknowledgement Letter. *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.*
Humana Response: Humana updated the referenced policies to address the Readiness Quality Improvement Plan Review comments for Line 25. Please refer to the following documents: • HM4200 – 07012021 – Policy(South Carolina Medicaid Standard Appeal First Level) – 001G • HM4200 – 07012021 – Policy(South Carolina Medicaid Expedited Appeal First Level) – 001B • Final HHH in SC Provider Manual at page 32-33 • Appeal Acknowledgement Letter	
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	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 member disagrees with the denial of expedited processing of an appeal.

Standard	EQR Comments
	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.
Humana Response: Humana updated the referenced policies to address the Readiness Quality Improvement Plan Review comments. Please refer to the following: HM4200 – 07012021 – Policy (South Carolina Medicaid Standard Appeal First Level) – 001G at page 7 HM4200 – 07012021 – Policy (South Carolina Medicaid Expedited Appeal First Level) – 001B at page 5	

Records of all appeals are monitored quarterly and presented to the Quality Assurance Committee. A review of committee minutes found appeal information was presented during the committee meetings and areas of concern noted.

Humana provided one appeal file. The file reflected the acknowledgement and resolution was completed timely. An appropriate physician reviewed the file and made the decision to uphold the original denial. The resolution notice contained the following errors. The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." Also, the language used to describe why the denial was upheld appeared to be above the 6th grade reading level.

Care Management

An overview of Humana's Care Management (CM) Program is found in the Care Management Program Description, which defines the program's goals, criteria for enrollment, methods and processes for enrollee identification and assessment, and management and evaluation of enrollee care and outcomes. Standard Operating Procedures containing information and instruction for staff conducting case management functions and activities include general care management, pediatric care management, and care management for the Moms First program. The CM Program Description lacks detail about the program's structure, such as departmental oversight, leadership, staffing positions, etc.

Humana receives CM referrals via various forums, such as referrals from state agencies, internal departments, eligibility files, community organizations, provider and

member/caregiver self-referrals, etc. Additionally, a predictive modeling and data analysis platform is used to stratify members by risk and identify enrollees who are potential candidates for CM services using data sources including, but not limited to, utilization patterns and data, diagnosis and procedure codes, claim and encounter data, and laboratory data. Further stratification is conducted via the Heath Risk Assessment (HRA) and comprehensive clinical and behavioral health assessments. Humana's stratification levels include Complex Care Management, Intensive Care Management, Care Management-Moderate Risk, and Care Management-Low Risk. Humana offers care management to all enrollees with Special Health Care Needs (SHCN) regardless of information gathered through the comprehensive assessment, the HRA, or predictive modeling.

Policy (UM-COC Policy)-008, Continuity of Care and Care Transitions, defines continuity of care activities and provides guidance for handling care transitions when members transfer into Humana Medicaid or from another MCO, members who disenroll from Humana and transfer to another MCO or Medicaid, and members whose provider is terminated from the Humana network.

The Care Management Program Description includes information about conducting an annual evaluation of the Care Management Program to determine opportunities for improvement and to inform revisions to the program. However, the program description does not provide detailed information about conducting satisfaction surveys with members who have been enrolled in the complex case management/disease management programs. Onsite discussion revealed Humana conducts these annually to assess member satisfaction.

Case Management files reflected consistent documentation of member consent for participation in Case Management activities. The file documentation confirmed staff consistently evaluate member needs, refer members to available community resources, assist with scheduling visits with providers and transportation for appointments, and address identified needs in care plans.

During the Readiness Review in 2020, it was noted that processes for ensuring Targeted Care Management (TCM) services are provided were not identified in policies or other documentation. Humana has corrected this issue by including information specific to TCM services in its Care Management Program Description. See Table 22 below for the findings from the Readiness Review and Humana's response to those findings.

Table 22: Readiness Review Care Management and Coordination QIP

Standard	EQR Comments
V. D Care Management and Coordination	
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	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 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.*
Humana Response: Humana has updated its Care Management Program Description to reflect Humana's process for ensuring TCM services are provided to the identified population per SCDHHS Contract Section 4.2.27. Please refer to the following document: HM4200 - 07012021 - Program Description (Care Management)-004 at page 13.	

Evaluation of Over/Underutilization

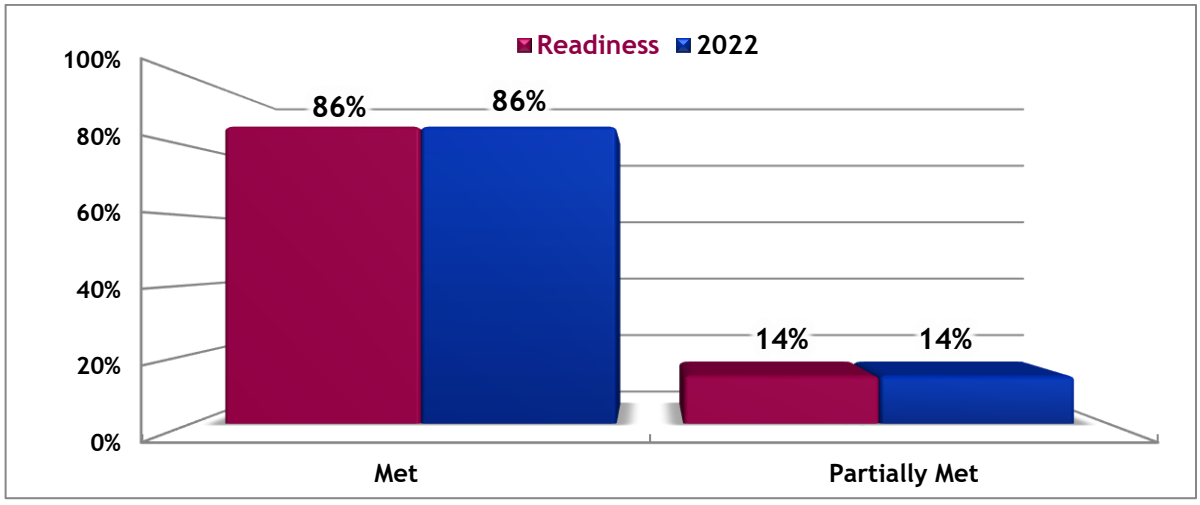
Policies for drug utilization, the Utilization Management Data Plan, and the Fraud, Research, Analytics and Concepts report for fraud management were submitted. The Utilization Management Data Plan offered some utilization indicators that will be monitored, including acute admits per 1000, inpatient days per 1000, readmission rates, ER visits per 1000, and others. All monitoring and assessment will be done by the Medical Management team and shared with the Quality Management team. There was no specific policy or action steps planned for addressing over- and underutilization. This was an issue identified during the Readiness Review. In response to this deficiency (see *Table 23: Readiness Review Over/Underutilization QIP*), the Utilization Management Data Plan stated that the Medical Management Committee "creates plans to mitigate when issues are identified." However, the process for how that is conducted was not clearly documented. During the onsite, staff indicated the Utilization Management Team was still building this out.

Table 23: Readiness Review Over/Underutilization QIP

Standard	EQR Comments
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	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.*
Humana Response: Humana has updated its UM Data Plan to reflect the process for monitoring over and underutilization.	

As noted in *Figure 7: Utilization Management Findings*, Humana achieved "Met" scores for 86% of the UM standards and "Partially Met" for 14% of the standards. One standard, monitoring and analyzing utilization data for over and underutilization, was scored as "Not Evaluated." Humana has not begun the process of monitoring over- and underutilization data.

Figure 7: Utilization Management Findings



Percentages may not total 100% due to rounding.

TABLE 24: Utilization Management Comparative Data

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to: timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Partially Met
	Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Partially Met	Met
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Partially Met
	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Met	Partially Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Partially Met
Appeal	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: The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Met
	The procedure for filing an appeal	Partially Met	Met
	Timeliness guidelines for resolution of the appeal as specified in the contract	Partially Met	Met

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
Appeal	The MCO applies the appeal policies and procedures as formulated	N/A	Partially Met
Care Management and Coordination	The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Partially Met	Met

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

Strengths

- Review decisions were timely, and members were notified of these decisions appropriately.
- Utilization Management files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
- Care Management files reflect consistent evaluation of member needs, referrals to available community resources, and assistance with scheduling provider visits and transportation. Care plans address member needs appropriately.

Weaknesses

- The UM Program Description contained errors regarding the Medical Management and the Quality Assessment Committees.
- Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provide a summary or the process used to manage the prior authorization list. Both policies contain basically the same information. Policy (Preauthorization List (PAL) Governance)-001 was watermarked as a draft and had an issue date of 2/25/2022. No explanation was provided regarding the purpose of both policies.
- The Focus policy, Initial Case Review V 14.0, incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.24.*
- To date, Humana has not conducted IRR testing despite a policy indicating that associates with at least three months tenure are expected to complete IRR testing.

- The Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation for when to use this contact information.
- Notices for PDL changes found on Humana's website did not contain evidence that the change was posted at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*
- Humana provided one appeal file. The resolution notice contained the following errors:
  - The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal."
  - The language used to describe why the denial was upheld appeared to be above the 6th grade reading level.
- The Care Management Program Description does not describe the structure of the Care Management Program.
- The Care Management Program Description does not provide detailed information about conducting satisfaction surveys with members who have been enrolled in the complex case management/disease management programs.
- There was not a specific policy or action steps planned for addressing the process for how the monitoring of over and underutilization will be conducted. This was an issue identified during the Readiness Review.

Quality Improvement Plans

- Correct the timeframes for completing non-expedited reviews and include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse treatments in the Focus policy, Initial Case Review V 14.0.
- Conduct Inter-Rater Reliability testing for all staff who render clinical determinations.
- Ensure notices of negative PDL changes are posted on Humana's website at least 30 days prior to the effective date as required by the *SCDHHS Contract, Section 4.2.21.2.3.*
- Correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.
- Develop a process for monitoring resolution notices to ensure letters contain correct reviewer information and the language meets the SCDHHS 6th reading level.

- Provide more detail in the Utilization Management Data Plan regarding issues identified during the monitoring of over- or underutilization. The data plan should include steps if monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.

Recommendations

- The UM Program Description should be updated to reflect the appropriate committee responsible for the oversight of UM functions. Also, remove the references to the Quality Assessment and Performance Improvement Committee.
- Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 and determine which policy best defines the process Humana uses to manage the Preauthorization List.
- Revise the Care Management Program Description to include the program's structure, to include departmental oversight, leadership, staffing positions, etc.
- Revise the Care Management Program Description to include detailed information about the processes for assessing member satisfaction specific to the Care Management Program. The information should include methods of survey, members who will be included, processes for conducting the survey, and processes for evaluating and reporting results of the survey.

F. Delegation

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

CCME's review of delegation functions included the submitted delegate list, sample delegation contracts, delegation monitoring materials, and delegation oversight documentation.

Humana reported delegation agreements with 10 entities, as shown in *Table 25: Delegated Entities and Services*.

Table 25: Delegated Entities and Services

Delegated Entities	Delegated Services
•Block Vision, Inc. DBA Superior Vision Benefit Management, Inc.	•Vision network management •Claims processing •Credentialing
•Focus Health, Inc. DBA Focus Behavioral Health, Inc.	•Behavioral Health network management •Claims repricing

Delegated Entities	Delegated Services
	•Utilization management
•ModivCare Solutions, LLC	•VAB •Non-emergent transportation services •Claims processing
•Network Medical Review Company, LTD	•Utilization management
•AnMed Health •Medical University Hospital Authority/MUSC Medical Center •Prisma Health University Medical Group •South Carolina Department of Mental Health •St. Francis Physician Services •United Physicians Inc.	•Credentialing

Processes and requirements for delegation are found in Policy (Delegation)-001 and the 2021 Subcontractor Monitoring and Oversight Plan. Policy(CORE Credentialing and Recredentialing)-001 addresses delegated credentialing requirements. Delegates are required to follow the NCQA credentialing and recredentialing standards and *SCDHHS Contract* requirements.

Prior to implementing a delegation agreement with a subcontractor, Humana conducts a pre-assessment of the entity to ensure it can perform the functions to be delegated in compliance with contractual, regulatory, accreditation, and health plan standards and requirements. For approved delegates, a written Delegation Services Addendum and Delegation Attachment are executed and serve as a written delegation agreement. They specify the delegated activities, the responsibilities of both the delegated entity and Humana, requirements for complying with Humana, state and federal law and accreditation organization requirements, processes for evaluating performance, and actions that may result if the delegate does not fulfill its obligations.

Humana retains accountability for all delegated services. Formal, annual evaluations are conducted to assess delegate performance and compliance to required standards. Ongoing monitoring is conducted via routine delegate reporting and Joint Operations Committee meetings.

For several credentialing delegates, Humana's submitted documentation indicated recommendations were offered or corrective action plans were implemented as a result of the delegates' annual audit; however, the submitted documentation did not include the recommendations and corrective actions. Additional information specifying the recommendations and corrective actions was submitted by Humana after the onsite visit. The Credentialing Annual Audit Tool used to assess credentialing delegates includes all

required elements for initial credentialing and recredentialing. CCME offered a recommendation to improve the tool so that it is clear Humana ensures credentialing delegates are querying both the SC Excluded Providers List and the SC Terminated for Cause List.

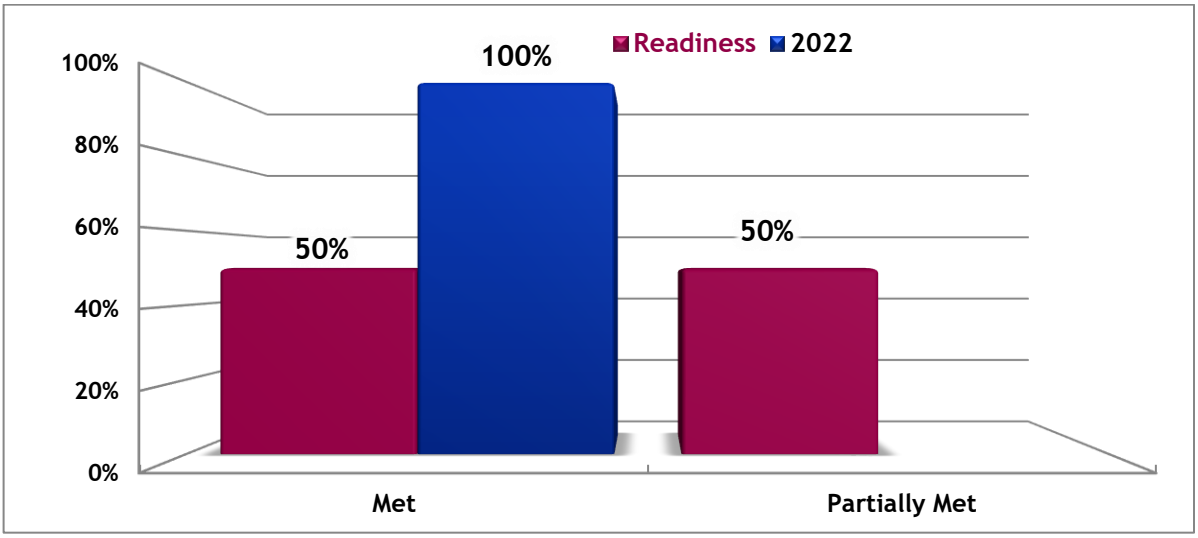
Humana implemented the Quality Improvement Plan from the 2021 Readiness Review by revising Policy (Delegation)-001 to address obtaining approval from SCDHHS for sub-delegation and to include requirements for checking the OIG and SAM on an ongoing basis. See *Table 26: Previous Delegation QIP Items from the Readiness Review*.

Table 26: Previous Delegation QIP Items from the Readiness Review

Standard	EQR Comments
V I. DELEGATION	
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	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.* *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.*
Humana Response: Please see Humana's revised HM4200 - 12012001 - Policy (Delegation)-001 at pages 7 & 9.	

As noted in *Figure 8: Delegation Findings*, 100% of the Delegation standards were scored as "Met."

Figure 8: Delegation Findings



Strengths

- Processes are in place to conduct pre-assessments of potential delegates' abilities to perform the selected delegated functions in compliance with contractual, regulatory, accreditation, and health plan standards and requirements.
- Written delegation agreement and specify the activities delegated, the responsibilities for both the delegated entity and Humana, requirements for complying with Humana, state and federal law and accreditation organization requirements, processes for evaluating performance, and actions that may result of the delegate does not fulfill its obligations.
- Ongoing delegate monitoring is conducted via annual audits, routine delegate reporting, and Joint Operations Committee meetings.

Weaknesses

- Column "BH" of the "Medicaid Reviews" tab of the Credentialing Annual Audit Tool contains both the SC Excluded Providers List and the SC Terminated for Cause List. This makes it unclear whether the delegate is monitored for querying both of these required lists.

Recommendations

- Include the SC Excluded Providers List and the SC Terminated for Cause List in separate columns on the "Medicaid Reviews" tab of the Credentialing Annual Audit Tool so that it is clear the delegates are querying both of these required lists.

G. State Mandated Services

42 CFR Part 441, Subpart B

The review of the State Mandated Services section of the EQR included an assessment of whether the health plan covers all required core benefits for members, health plan processes for tracking provider compliance with administering required immunizations and performing EPSDT/well care services, and the degree to which the health plan addressed deficiencies identified during the 2021 Readiness Review.

Through documentation review and onsite discussion with Humana staff, it was determined that Humana covers all required core member benefits.

Policy (NNO 702-040 Physician Performance Measurement) – 007 describes Humana's methodology for evaluating provider performance. For South Carolina Medicaid, several resources are to obtain provider data including, Software – OptumTM Symmetry® EBM Connects, and Quest Analytics Suite. Onsite discussion revealed Humana will run a Stars Quality Report monthly that will display gaps in care and will be given to providers. The plan also reported that providers will be able to access the information "on-demand." Examples of reporting documents that will be used were provided.

The *SCDHHS Contract, Section 4.2.10.1,* requires MCOs to "Have written Policies and Procedures consistent with *42 CFR 441, Subpart B*, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults." A policy and/or procedure was not identified describing processes for monitoring provider compliance specific to performing EPSDT/well-care services for members or for administering immunizations. Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations or with performing EPSDT/well care services.

Humana did not implement the Quality Improvement Plans corrections to address deficiencies identified during the 2021 Readiness Review related to:

- Collecting full collaborative agreements between nurse practitioners and their supervising/collaborating physician(s) at initial credentialing and recredentialing.
- Ensuring letters notifying providers of credentialing and recredentialing determinations are dated on or after the date of the credentialing/recredentialing determination.
- Developing specific policy or action steps for addressing the monitoring of over- and under-utilization.

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

Figure 9: State Mandated Services

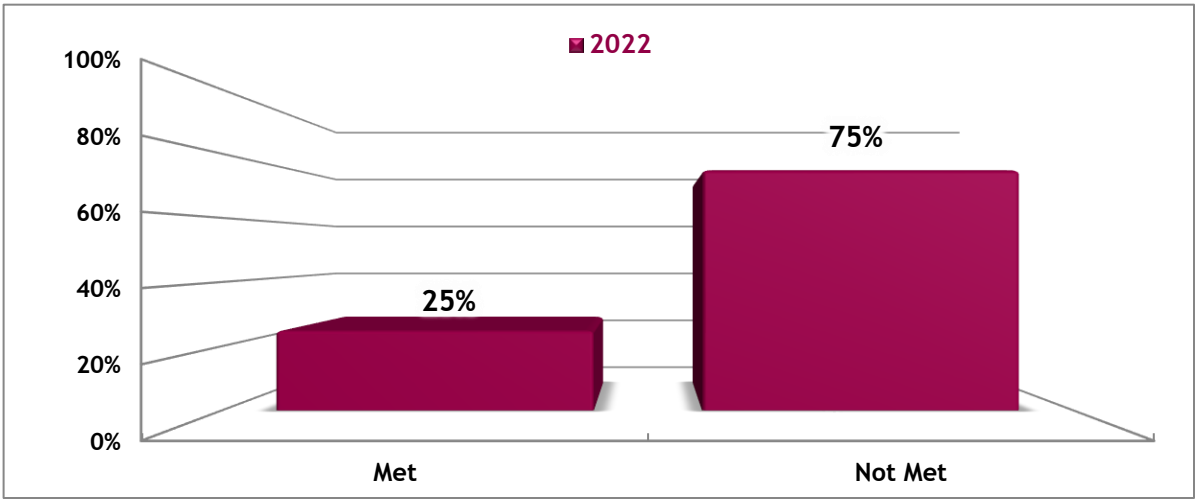


Table 27: Provider Services Comparative Data

SECTION	STANDARD	READINESS REVIEW	2022 REVIEW
State-Mandated Services	The MCO tracks provider compliance with: Administering required immunizations	N/A	Not Met
	Performing EPSDTs/Well Care	N/A	Not Met
	Core benefits provided by the MCO include all those specified by the contract	N/A	Met
	The MCO addresses deficiencies identified in previous independent external quality reviews	N/A	Not Met

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

Strengths

- Humana covers all required core benefits for members.

Weaknesses

- Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations.
- Humana presented no evidence that it is currently tracking provider compliance with performing EPSDT/Well Care services.

- The *SCDHHS Contract, Section 4.2.10.1* states MCOs must "Have written Policies and Procedures consistent with *42 CFR 441, Subpart B*, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults."
- Humana did not implement the Quality Improvement Plans from the 2021 Readiness Review to address the following deficiencies identified during the Readiness Review:
  - Action was not taken to ensure credentialing and recredentialing files include full collaborative agreements between nurse practitioners and their supervising/collaborating physician.
  - Action was not taken to ensure letters notifying providers of credentialing and recredentialing determinations are dated on or after the date of the credentialing/recredentialing determination.
  - There was not a specific policy or action steps planned for addressing the monitoring of over-and under-utilization.

Quality Improvement Plans

- Implement activities to track provider compliance with administering required immunizations.
- Develop a written policy and procedure for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible members.
- Implement activities to track provider compliance with performing EPSDT/well care services for members.
- Address and implement actions to correct all identified deficiencies.

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

January 10, 2022

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 Annual External Quality Review (EQR) of Humana is being initiated. An external quality review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. Due to COVID-19 the two day onsite previously performed at the health plan's office will be conducted virtually. The CCME EQR team plans to conduct the virtual onsite on **March 2, 2022,** and **March 3, 2022.**

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **January 24, 2022.**

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

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2022

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

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

Excel Spreadsheet Format

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

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

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

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

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

hybrid methodology, including data sources and how the sample was chosen; or survey, including a copy of the tool, how the sample was chosen and how the data was input), including a full description of the procedures;

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

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

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2022

MATERIALS REQUESTED FOR ONSITE REVIEW

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

2. Copy of the HUM-Centralized Services-**PAL-001** Preauthorization List (PAL) Governance policy. We received the HUM-Centralized Services – PAL – 002 Preauthorization (PAL) Governance policy.

3. A copy of the most recently conducted Geo Access study.

4. A copy of the policy that covers the process for handling/reviewing hysterectomies, sterilizations, and abortions.

5. A copy of the Core Benefits and Services Policy HM4200-7/1/21-(UM)-002 and attachment Specific Core Benefits and Services Listing Grid.

6. A copy of the Emergency and Post Stabilization policy.

7. The UM policy for Inter-Rater Reliability Monitoring and the results of the most recent monitoring conducted for physician and non-physician reviewers.

8. A copy of the Cultural Competency Plan.

9. A copy of the following documents referenced in the Medicaid and Dual Demonstration South Carolina Medicaid Grievance and Appeal Policy – 001A:
   a. Medicaid & Dual Demonstration Policy Reg Chart Job Aid,
   b. Examples of Split Case Job Aid,
   c. Medicaid Med Supp Grievance Interactive Flow,
   d. G&A Vendor & Delegate Procedures,
   e. Humana's Procedure for Pharmacy Restrictions Medicaid Members,
   f. Medicaid Extension Procedure, and
   g. Case File Summary Policy.

10. A copy of the New Provider Orientation Checklist.

11. A copy of the most recent MyPractice newsletter.

12. Provide a copy of the draft template report Humana's intends to use to measure provider performance.

13. An example of the Stars Quality Report and the Electronic Attestation Form completed for a SC provider.

14. Compliance Committee Charter and minutes.

C. Attachment 3: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Humana Healthy Horizons
Collection Date:	2022

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.		X				The 2022 EQR found that policies and procedures are in place indicating that some of Humana's action steps in response to the Readiness Review finding were implemented. However, not at a comprehensive level. Many policies did not reflect consistent annual reviews by all departments. Some policies were last reviewed in 2020. A few examples include Policy (Continuity of Care)-010 last reviewed 11/5/2020, Policy (HPS Audit Discrepancy List Code)-001 last reviewed 11/5/2020, and Policy (Surveillance Policy)-001A last reviewed 9/7/19. Clusters of policies not reviewed within the last twelve months were found for information, technology, and data systems policies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Complete a comprehensive review of policies to reflect a current review cycle. Consolidate multiple existing policies with similar content.
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						The 2022 EQR found that previously identified vacant positions have been filled. The organizational chart demonstrates there is sufficient staff available to meet contract requirements.
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. Kim McElroy is Humana's Chief Executive Officer (COO).
1.2 Chief Financial Officer (CFO);	X					The Chief Financial Officer is Maria Pepitone.
1.3 * Contract Account Manager;	X					The Contract Account Manager is Taffney Hooks.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					Julie Spencer is the Claims and Encounter Manager.
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					The Director of Utilization Management is Nadelyn Morales.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.1 Pharmacy Director,	X					The Pharmacy Director is Melissa Pearutt.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Quality Improvement is led by is Ashley Franciscus.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					The Provider Services Manager is Gina Ruiz.
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;	X					The Member Services Manager is Taffney Hooks.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					The Medical Director is Dr. Ayo Gathing.
1.10 *Compliance Officer;	X					The Compliance Officer is Regina Moore.
1.10.1 Program Integrity Coordinator;	X					
1.10.2 Program Integrity FWA Investigative/Review Staff;	X					
1.11 * Interagency Liaison;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.12 Legal Staff;	X					Andrew Murr is Humana's legal representative.
1.13 Board Certified Psychiatrist or Psychologist;	X					Dr. Ayo Gathing is a Board Certified Psychiatrist.
1.14 Post-payment Review Staff.	X					
2. Operational relationships of MCO staff are clearly delineated.	X					
I C. Management Information Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Humana sets its claim timeliness benchmarks to be at least what is required by State contract(s). In addition to meeting or exceeding timeliness requirements, Humana works to achieve 99% financial accuracy, 98% payment accuracy 98%, and 97% processing accuracy for all claims.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Humana maintains a web portal for electronic claims data to be submitted. Presently, 97% of Humana's claims data is submitted electronically. Additionally, the MCO requires submitted data to adhere to X12-837 and NCPDP formats to ensure accuracy and completeness.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					In addition to regularly processing State provided 834 files, Humana's systems link enrollee data across each of its product lines to minimize inaccuracies and prevent duplication. If a duplicate enrollee is found or suspected, Humana reviews the data and combines the enrollee profiles.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 duplicates its production data to a dedicated data warehouse for reporting. The MCO uses the dedicated data warehouse to feed info to its NCQA certified HEDIS vendor. Humana's HEDIS vendor provides reporting and provides the MCO with chain of trust documentation to ensure data is handled without error.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Humana's ISCA documentation indicates the MCO has a focus on best-practices IT security. The policy documentation provided is frequently reviewed and updated, as indicated by timestamps. Additionally, Humana has policies which require its data to be classified. Data classification is a best practice measure that standardizes how data is handled and shared.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Humana has policies and procedures to manage user identities, account access, authentication, and system access. The MCO requires all access changes to be reviewed and approved by management before they are executed. Finally, the organization's access policies are also applied to its contractors, vendors, and business partners.
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					The ISCA documentation provided shows that Humana has a detailed and well thought out disaster recovery plan. The MCO replicates its data to a remote data center to keep data available if there is a disaster at its primary location. The Disaster Recovery/Business

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Continuity Plan policy is reviewed frequently and updated as needed.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Policy (Humana Corporate Compliance Plan)-001C, outlines Humana's guidelines for creating a workplace climate in which ethics are integral to day-to-day operations. The Compliance Plan is reviewed annually, and input is provided to the corporate team for revisions as needed.
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Ethics Every Day document provides definitions of key ethical principles, examples of daily recognition of potential violations, reporting processes, potential outcomes, and subsequent investigations.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Officer is identified in the Organizational Chart and the Compliance Plan.
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						The Corporate Compliance Committee is chaired by the CCO and is comprised of Humana's CEO and full executive leadership team, compliance officers, the Chief Audit Officer, and other senior leaders.
2.5 Compliance training and education;						Compliance and FWA training is required annually for all Humana associates, including the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Chief Executive Officer, senior leaders, the Board of Directors, and contingent labor. Curriculum modules include review integrity, conflicts of interest, information protection, privacy, FWA and general compliance, workplace conduct, and marketing practices.
2.6 Lines of communication;						
2.7 Enforcement and accessibility;						Avenues for reporting suspected FWA are clearly defined on the Humana's website, in the Member Handbook, and in the Provider Manual. Telephonic, electronic, or mail options are provided.
2.8 Internal monitoring and auditing;						The Compliance Plan documents that monitoring and auditing are conducted to identify compliance risks. This process 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;						The Enterprise Investigations Consortium conducts investigations for potential misconduct, FWA, criminal activity, and ethics and compliance concerns, including concerns received via the Ethics Help Line, to provide a basis for managing risk.
2.10 Data mining, analysis, and reporting;						
2.11 Exclusion status monitoring.						
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					The role of the Compliance Committee is described in the 2021 Compliance Plan and membership is detailed in the Medicaid Medicare Compliance Committee Charter. Compliance Committee minutes do not document meeting attendees, the establishment of a quorum, and motions and actions taken by the committee and subcommittees. *Recommendation: Ensure future Compliance Committee minutes record attendees, the establishment of a quorum, and track tasks completed by the committee and subcommittees.*
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					
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, states that all personal facts and circumstances concerning members or potential members are treated as privileged and confidential. The policy contains contract language but does not include processes to outline how this is conducted. *Quality Improvement Plan: Review Policy (General Contractual Conditions Confidentiality Policy)-022, and include the steps and processes used to safeguard confidential information.*

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.		X				Humana has a written Credentialing & Recredentialing Program Description. The enterprise-wide CORE Credentialing and Recredentialing(23rd ed)-001A policy addresses general credentialing and recredentialing requirements for individual practitioners and organizational providers. Requirements specific to South Carolina Medicaid provider credentialing and recredentialing are found in Policy (CORE Credentialing and Recredentialing)-001. The policies address most credentialing and recredentialing elements, including the scope of practitioners who must be credentialed, information to be collected and verified by the MCO, acceptable verification sources, the review and determination process, provider appeal rights, and requirements for non-discrimination against providers in high risk/high cost patient specialties. However, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						South Carolina requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001. *Quality Improvement Plan: Revise Policy (CORE Credentialing and Recredentialing)-001 to specify that querying the SCDHHS Termination for Cause List is a required element for initial credentialing and recredentialing for all practitioners and organizational providers.*
2. Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO.	X					The 2022 South Carolina Medicaid Credentials Committee began operations in December 2021. The committee charter defines the purpose and structure of the committee. Meetings are held at least monthly, and the quorum is defined as the presence of at least 75% of voting members. Membership of the committee includes at least 1 SC Humana Medical Director, who serves as the committee Chair, and external committee members who are actively practicing practitioners who are contracted as participating providers in Humana's network. The committee membership includes at least one PCP,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specialist, pharmacist, allied health provider and behavioral health provider. When reviewing the attendance documentation for the December 2021 South Carolina Medicaid Credentials Committee minutes, it was noted that two internal staff member attendees (with titles listed as a Credentialing Professional 2 and Credentialing Operations) were listed in the "Voting Members" section. Onsite discussion confirmed this was incorrect and these staff members should have been included in the "Non-Voting Humana Staff" section of the minutes. Also, the header of the December 2021 South Carolina Medicaid Credentials Committee minutes states, "Louisville Credentials Committee Agenda." *Recommendation: Ensure non-voting members of the South Carolina Medicaid Credentials Committee are listed in the correct location of the minutes. Correct the heading of the minutes to reflect South Carolina instead of Louisville.*
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.			X			Review of initial credentialing provider files submitted by Humana revealed:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•For 14 of 16 files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. **This is a repeated finding from the Readiness Review.** •Two initial credentialing files for nurse practitioners were submitted. Both files were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.* **This is a repeated finding from the Readiness Review.** *Quality Improvement Plan: Ensure practitioner credentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. 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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;			X			None of the 16 initial credentialing provider files included evidence of querying the SCDHHS SC Providers Terminated for Cause List. This was discussed during the onsite, and Humana provided the following response after completion of the onsite: "I have confirmed the verification of the "termed for cause list" was not completed for any of the credentialing and recredentialing files reviewed during the audit period. I acknowledge this is a gap in our existing process and we are working to close this gap immediately. Collection and verification of the "termed for cause list" distributed by SC DHHS is a planned area of focus that we will be re-educating and auditing more stringently going forward." *Quality Improvement Plan: Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at initial credentialing and that the credentialing files include evidence of the query as well as the date of the query.*
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				Four initial credentialing files did not include evidence of the query of the Social Security

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Administration's Death Master File. Evidence of queries of the Social Security Death Master File were submitted after the onsite for the four files in question; however, the queries indicate they were conducted on March 3, 2022, and not prior to the initial credentialing determination for the four providers. *Quality Improvement Plan: Ensure all initial practitioner credentialing files include evidence of querying the Social Security Death Master File prior to the initial credentialing determination.*
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.			X			Review of recredentialing provider files submitted by Humana revealed: •For 14 of 16 files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee approval date. •Two recredentialing files for nurse practitioners were submitted. Both files were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.* *Quality Improvement Plan: Ensure practitioner credentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. 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.

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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;			X			Zero of 16 recredentialing provider files included evidence of querying the SC Providers Terminated for Cause List. This was discussed during the onsite, and Humana provided the following response after completion of the onsite: "I have confirmed the verification of the "termed for cause list" was not completed for any of the credentialing and recredentialing files reviewed during the audit period. I acknowledge this is a gap in our existing process and we are working to close this gap immediately. Collection and verification of the "termed for cause list" distributed by SC DHHS is a planned area of focus that we will be re-educating and auditing more stringently going forward." *Quality Improvement Plan: Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at recredentialing and that the recredentialing files include evidence of the query as well as the date of the query.*
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);		X				Six recredentialing files did not include evidence of the query of the Social Security Administration's Death Master File. Evidence of queries of the Social Security Death Master File were submitted after the onsite for the six files in question; however, the queries indicate they were conducted on March 3, 2022, and not prior to the recredentialing determination for the six providers. *Quality Improvement Plan: Ensure all practitioner recredentialing files include evidence of querying the Social Security Death Master File prior to the recredentialing determination.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					The 2021 Quality Assessment and Performance Improvement Program Description, page 24, states the Peer Review Committee (PRC) is responsible for reviewing potential quality of care issues, determining the severity of the issue, and recommending quality improvements or corrective actions as appropriate. The PRC is responsible for development of individual provider quality improvement plans, where indicated, and review of progress toward resolution. Policy (CORE Credentialing and Recredentialing (23rd ed))-001A indicates Humana monitors practitioner sanctions, complaints, and quality issues between recredentialing cycles and takes corrective action when occurrences of poor quality are identified. Ongoing monitoring and interventions, up to and including removal from the network, are implemented when the provider is determined to have Medicare or Medicaid sanctions or exclusions, license sanctions or limitations, complaints, and identified adverse events.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy (NNO 703-016-18 Medicaid Provider Terminations and Member Notifications)-005 describes the provider termination and member notification process.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.			X			Thirteen initial credentialing files were submitted for organizational providers. The following issues were noted: •For 12 initial credentialing files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review. •The query of the SCDHHS Excluded Provider's Report was conducted three months after the determination date for 1 file. •None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List. Fifteen recredentialing files were submitted for organizational providers. The following issues were noted: •For 12 recredentialing files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List. *Quality Improvement Plan: Ensure organizational provider credentialing and recredentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every organizational provider at initial credentialing and recredentialing, and that the files include evidence of the query as well as the date of the query.*
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.		X				Policy (Core Sanctions Policy)-002 states "Humana monitors practitioner sanctions, exclusions, and debarments between recredentialing cycles and ensures that corrective actions are undertaken and effective when it identifies occurrences of such instances." Ongoing monitoring and appropriate interventions up to and including removal from the network are implemented by collecting and reviewing Medicare/Medicaid sanctions and exclusions, licensure

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						sanctions/limitations, and identified adverse events within 30 calendar days of release. Credentialing staff are notified of publications that include a weekly sanction pull from: •Council for Affordable Quality Healthcare (CAQH)—includes providers with state license sanctions and exclusions/sanctions from the Office of Inspector General (OIG) List of Excluded individuals/Entities (LEIE) •System for Award Management (SAM) publications •State Medicaid exclusion notifications •Office of Personnel Management (OPM) debarment reports The policy states that at least every 30 days, credentialing staff review the South Carolina Excluded Providers list for newly excluded providers. However, the policy does not include that the SCDHHS SC Providers Terminated for Cause List is also monitored. Credentialing staff search the Provider Master Data Management (PMDM) system to confirm the identity of the sanctioned provider. Medicaid practitioners will have action taken no later than 48 hours of discovery of the sanction. Once a provider is confirmed,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						documentation is saved, and a certified letter is drafted to notify the provider of the termination. *Quality Improvement Plan: Revise Policy (Core Sanctions Policy)-002 to include the SCDHHS SC Provider Terminated for Cause List as a required monthly monitoring element.*
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						Humana reported during the onsite that Geo access mapping is performed twice yearly and as needed. Network analysis is conducted at least every other week. The South Carolina Medicaid Network Adequacy Report, updated January 11, 2022, with data as of January 7, 2021, displays provider network detail by county and provider specialty type. The report displays current as well as previous results. The Provider Support Plan 2022 (found in Policy and Procedure HUM- SC-PR-011, SC Medicaid Network Availability and Access) states Humana analyzes provider-to-enrollee ratios monthly against network standards. Onsite discussion confirmed Humana monitors member to provider ratios at least biweekly. Humana also

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						tracks providers with open and closed panels on an ongoing basis through the provider network directory extract file.
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 the access standard for primary care providers (PCPs) as: 90% of the anticipated SC Medicaid Membership population in the county must have access to at least one PCP within 30 miles and 45 minutes or less driving time. Providers with specialties of Family Practice, General Practice, Internal Medicine, Pediatrics, Federally Qualified Health Centers, and Rural Health Clinics are considered to be PCPs. The South Carolina Medicaid Network Adequacy Report, updated January 11, 2022, indicates goals were met for PCP access for all counties.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Policy (SC Medicaid Network Availability and Access)-004 appropriately defines access standards for required specialists and hospitals. The South Carolina Medicaid Network Adequacy Report, updated January 11, 2022, reflects that Humana contracts with all required Status 1 provider specialty types and hospitals. The report indicates network gaps were identified in a few counties for the following: •Rehabilitative Behavioral Health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Hematology and Oncology •Gastroenterology •Otolaryngology/Otorhinolaryngology •Speech and Audiology Therapy These network gaps were discussed during the onsite and Humana reported some of the gaps have since been closed, and efforts continue to recruit providers to close the remaining gaps. For members affected by any current network gaps, Humana will execute an agreement with out-of-network providers and authorize members to see those providers.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					
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					Humana has activities in place to ensure its provider network is able to serve members' cultural needs and other special needs as well as assessing the plan to ensure members' needs are met. Activities include: •Assessing the membership ethnicity and racial diversity. •Educating staff about cultural competency and sensitivity as well as health literacy. •Ensuring member materials are made available in appropriate formats and translations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Utilizing telecommunications device for the deaf (TDD) services, translator services, and braille translations. •Providing cultural competency resources and training to providers. •The Corporate Bold Gold Initiative, which focuses on the impact of food insecurity and social isolation. The Provider Manual states it is a provider responsibility to "provide services in a culturally competent manner" by removing language barriers, providing interpretation services as needed, and accommodating patients' special ethnic, cultural and social needs. Included in the Provider Manual are links to the USDHHS Office of Minority Health to obtain more information. However, one of the links provided of page 37 is non-functional (https:www//thinkcultural health.hhs.gov/). The Provider Manual, page 44, gives an overview of Cultural Competency and includes a link to a copy of Humana's Cultural Competency Plan on the website, However, the link was non-functional. The Cultural Competency Training 2022 document is available on the Humana website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Correct the link to the USDHHS Office of Minority Health on page 37 of the Provider Manual. Correct the link to Humana's Cultural Competency Plan on page 44 of the Provider Manual.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements.	X					Policy (On-line Provider Finder Tool and Hardcopy Directories) – 003 states "Humana electronically posts a current and accurate provider directory for each of its network plans. The electronic directory is made available to the general public to view all of the current providers for a plan through a clearly identifiable link or tab on the Humana website without creating or accessing an account or entering a policy or contract number." Humana provides printed copies of the Provider Directory upon request. The policy lists elements that must be included in the Provider Directory, but fails to include office hours, website URLs, and provider abilities to accommodate individuals with physical disabilities. However, all required elements were noted in both the print version

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						of the Provider Directory and the online "Find a Doctor" tool. *Recommendation: Revise Policy (On-line Provider Finder Tool and Hardcopy Directories) - 003 to include all elements that must be included in the Provider Directory. Refer to 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 PCP and specialty appointment availability standards that are compliant with contractual requirements. The policy states provider availability is monitored using CAHPS survey results, complaint and grievance data, requests for out of network provider agreements, and Mystery Shopper Survey results. For providers who do not meet availability standards, a corrective action plan detailing deficiencies and recommendations for improvement is implemented. Quarterly meetings are conducted to review and discuss progress. If the provider's performance does not improve during the agreed timeframe, actions may include restricting provider participation or termination from the network.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						This policy does not specify the frequency for conducting the Mystery Shopper Surveys. Onsite discussion confirmed Humana has not yet conducted a Mystery Shopper Survey but plans to conduct one in July 2022. *Recommendation: Revise Policy (SC Medicaid Network Availability and Access)-004 to define the frequency for conducting Mystery Shopper Surveys.*
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.					X	As part of the annual EQR process for Humana, a provider access study focusing on primary care providers was performed by CCME. A list of current providers was given to CCME by Humana, from which a population of 2,170 unique PCPs was identified. A sample of 172 providers was randomly selected from the identified provider population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. For the Telephone Provider Access Study conducted by CCME, calls were successfully answered 55% of the time (84 out of 154) when omitting calls answered by personal or general voicemail messaging services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						For calls not answered successfully (n = 70 calls), 36 (51%) were because the provider was no longer an active PCP at that location. When asked if the provider accepts Humana, 70 of 84 providers (83%) confirmed that they do accept Humana. Of those 70, 49 providers (70%) confirmed they were accepting new Medicaid patients. Of the 49 providers, 14 (29%) indicated they do have prescreening requirements. Of the 14 providers with prescreening requirements, one (7%) required an application, six (43%) required a medical record review, five (36%) required both and two (14%) required vaccine records. The access study also assesses routine appointment availability by asking "Is there a new patient appointment in the next 4 weeks for this provider?" For Humana, 11 of 49 providers who answered the question (22%) did not meet the requirement of a routine appointment within 4 weeks. *Recommendation: Conduct routine outreach to all providers, particularly primary care providers, to verify demographic information and to re-educate staff on appointment*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						standards and lines of business for network participation. Conduct additional internal audits to verify the accuracy of the provider file.
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 and Procedure (Provider Training)-009 describes processes for initial and ongoing provider education, and includes topics covered during orientation and training sessions. Provider orientation is conducted within 30 days of a provider's contract effective date. Ongoing provider education training is conducted throughout the year for program changes via monthly in-services with PCP offices, ad hoc provider meetings and webinars, periodic newsletters, annual compliance training, etc. Issues identified in Policy (Provider Training)-009 include: •Page 2, item #1 states, "If necessary to accommodate preferences of office staff, the below may be mailed." However, the policy does not list what may be mailed. •Page 3 of the policy lists materials that are available on the website. The list includes the "Louisiana Medicaid provider manual." This is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						an issue CCME noted during the 2021 Readiness Review and recommended that Humana correct. •The policy makes multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist These references were noted in item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four. Humana confirmed that a New Provider Orientation Checklist and New Provider Orientation and Provider Training Checklist are not used. *Quality Improvement Plan: Revise Policy (Provider Training)-009 to include items that may be mailed to providers (page two, item #1). Also, remove the reference to the Louisiana Medicaid provider manual (page 3) and remove references to the New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist (item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four).*
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;		X				The Provider Orientation and Training Slides document addresses covered services, member costs, EPSDT services, telehealth visits, pharmacy benefits, excluded services, and added benefits. Information about member benefits is included in the Provider Manual; however, the following issues were identified: •Page nine states audiological services are covered but does not provide limitations to this coverage or indicate hearing aids for members 21 and over are not covered. See the *SCDHHS Contract, Section 4.2.4.* •Page nine states chiropractic services are covered and limited to manual manipulation of the spine to correct a subluxation. However, it does not include the limitation of six visits per year. See the *SCDHHS Contract, Section 4.2.6.* •Pages 28 states Humana uses the Universal BabyNet Prior Authorization Form but does not provide any information about the BabyNet program. See the *SCDHHS Contract, Appendix E.* •The Provider Manual does not indicate that newborn hearing screenings are covered when

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						rendered to newborns in an inpatient hospital setting. See the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18.* Additionally, this benefit is not included in Policy (UM – Core Benefits and Services)-007. *Quality Improvement Plan: Revise the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. Revise Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting.*
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					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
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					
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					Policy Clinical Practice Guidelines – Medical and Behavioral QM-001-17 is a corporate policy that describes processes for identifying, adopting, and conducting ongoing review of clinical practice and preventive health guidelines. The corporate Clinical Practice Guideline Committee meets biannually to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						review Humana's adopted guidelines. The committee includes Humana medical directors, including Behavioral Health, various specialty areas, and external physicians, and a designated Humana Medical Director chairs the committee. The guidelines are presented to the Humana Corporate Quality Improvement Committee for approval and then forwarded to the Quality Operations Compliance and Accreditation Market Directors for inclusion at the local market level. At least three times yearly, a designated corporate team checks for updates to the adopted guidelines, appropriateness of clinical topics, and whether the national guideline and organization used continues to be the most widely accepted. As noted in Policy (Clinical Practice Guidelines)-010 [QM-001-17], a local health plan supplement to the corporate policy, website links to the guidelines are reviewed quarterly to confirm they are correct, and that the guideline remains current and the most relevant. Suggestions for new guidelines may be identified from a variety of sources such as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						membership needs, physician case review, business needs or requirements, and identified trends or public health issues. A Clinical Practice Guideline Adherence (CPGA) process was developed to monitor provider adherence, including SC providers, to the Clinical Practice Guidelines (CPG). Providers are identified for potential investigation if they are in the bottom 1% for four or more elements for two consecutive quarters. Metrics on CPGA investigations are included in the Quality of Care Investigation Executive Summary presented to the Humana Healthy Horizons in South Carolina Quality Assurance Committee. Updates to the guidelines are communicated to the market plans as needed.
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					Policy (Clinical Practice Guidelines)-010 [QM-001-17] states approved guidelines are available to SC providers on Humana's website, and guideline changes and updates are announced in provider newsletters. The Provider Manual, page 48, includes an overview of preventive health and clinical practice guidelines, and states guidelines are disseminated to new and existing providers through Provider Manual updates, provider

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						newsletters, and the provider website. Providers also can request PHGs and CPGs through the Care Management Department or Provider Relations Representative. The Provider Manual also informs that Humana will monitor provider compliance to the guidelines through claim, pharmacy, and utilization data.
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II E. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.	X					
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Policy (Coordination of Care) describes Humana's process for monitoring coordination of care between providers and includes methods of monitoring, assessment, and addressing identified deficiencies. To ensure appropriate coordination of care, Humana analyzes data between settings of care and in transitions of care from one provider to another. Information sources include: •ambulatory medical record reviews (including clinical studies, quality reviews, and HEDIS measurements), which monitor physician and facility correspondence contained within the medical record

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•HEDIS measurements •CAHPS results •data from disease/case management, appeals, and grievance •utilization management and pharmacy activities to coordinate care across healthcare settings and providers Data from coordination of care activities are reviewed at the Quality Assurance Committee (QAC) per the schedule established on the Quality Improvement Work Plan. Report owners provide an analysis of the measures, identify barriers, and offer recommendations for improvement. The QAC may approve the recommendations and/or make additional recommendations.
II G. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy (Medical Record Review) - 013 [HUM-SC-QM-006] documents medical record standards and outlines the Humana's processes for conducting provider medical record reviews (MRRs). Humana determines a physician sample size based on state requirements and market membership, and the Quality Compliance Nurse conducts the MRR using approved medical record documentation criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The record review goal is 90% but the minimum threshold is 85%. For physicians do not meet the 85% threshold, a re-audit occurs approximately 6 months after the initial review. Physicians are informed in writing of their results and may be provided with the Medical Record Review criteria and/or resources and provider education for assistance in improving documentation practices. Results are submitted to the Associate Director Quality Improvement and an evaluation of the physicians' scores is submitted to the SC Medicaid Quality Assurance Committee for input on additional actions. The Credentialing Department considers MRR results at provider recredentialing.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Medical record documentation standards are found in Policy (Medical Record Review) - 013 [HUM-SC-QM-006] and in the Provider Manual.
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 2021 Quality Assessment and Performance Improvement 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.”

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Policy (Medical Record Review)- 013 [HUM-SC-QM-006] does not define the frequency of the medical record reviews. Onsite discussion confirmed Humana will conduct MRR at least annually and more often if needed. Humana staff confirmed that an MRR was not conducted in 2021 but one is planned for Q2 or Q3 of 2022. *Recommendation: Revise Policy (Medical Record Review)- 013 [HUM-SC-QM-006] to include the frequency of the provider medical record reviews.*
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
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					SC Humana Healthy Horizons™ provides notifications of member's rights and responsibilities via the Welcome Packet, Member Handbook, Humana website, and in Policy (Member Rights)-028.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
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, list the items received by new enrollees in the Welcome Packet, including 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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member Portal, the Member Handbook, and Provider Directory.
1.1 Benefits and services included and excluded in coverage;						Policy (UM- Core Benefits and Services)-007 indicates Humana includes benefit information in the Member Handbook. However, the Member Handbook does not include the limit on the number of chiropractic visits or information about communicable disease services, newborn hearing screenings, rehabilitative therapies for children, and transplant services are not included in the Member Handbook. Also, BabyNet Services are not included in the Member Handbook, Policy (UM-Core Benefits and Services)-007, or in the SC TANF CHIP Specific Core Benefits grid. *Recommendation: Revise the Member Handbook and include the limitation on the number of visits for chiropractic services and information about communicable disease services, newborn hearing screenings, rehabilitative therapies for children, and transplant services. Also include information about BabyNet services in the Member Handbook, Policy (UM-Core Benefits and Services)-007, and in the SC TANF CHIP Specific Core Benefits grid.*
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						Out-of-network providers are required to have an authorization from Humana. Services that require prior authorization are listed in the Member Handbook, Provider Manual, and Humana website. Prior approval is not required for family planning services and emergency visits.
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						Members are 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;						

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;						
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					Policy (MARKETING)-001 describes the processes to ensure member materials are written in a clear and understandable manner and meet contractual requirements. Written communication is provided 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.
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					Call Center processes are outlined in Policy (Toll Free Line)-021, and the Standard Operating Procedure-Call Center Operations-Toll Free Line document describes Humana's approach for providing 24-hour access availability for members in South Carolina, according to requirements in the *SCDHHS Contract*.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion described the levels of training provided to Call-Center agents. In addition to a 6-week initial training, side-by-side, coaching, and leader-led huddles are forums for additional trainings.
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					
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					Onsite discussion outlined that information is made available to Members on the Humana website and social media on disease management and chronic disease management. Case Managers and Call-Center staff also make members aware of new health initiatives. Call Center staff conduct phone and text campaigns.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					
III E. Member Satisfaction Survey						
1. The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. This assessment includes, but is not limited to:					X	Annually, Humana conducts a Member Satisfaction Survey. Humana has contracted with SPH Analytics to conduct the CAHPS Survey for the Adult, Child, and Child with Chronic Conditions populations. SPH Analytics is on track for reporting the results in June/July 2022. Therefore, the Validation of the Member Satisfaction Survey was not conducted for this EQR. Humana also mentioned the timeline for administering the ECHO survey is scheduled to start in March 2023.
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	

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 Adverse MCO claim decisions.					X	
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					
1.1 The definition of a grievance and who may file a grievance;	X					The term “grievance” is defined in Policy (Grievance and Appeals)-011, the Humana website, Member Handbook, and Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;	X					Grievance timelines are outlined in policy (South Carolina Grievance First Level Review)-001F, and the Humana website has a link to the Appeal, Complaint or Grievance Form. Grievances are acknowledged within five business days with resolution to be completed within 90 calendar days.
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.		X				Humana submitted seven grievance files for review. •Two of the seven files did not meet Humana's timeliness policy for sending an acknowledgement letter. •One file was noted as still in progress. This grievance was received on November 16, 2021 and should have been resolved by February 14, 2022. There was no information regarding a request for an extension.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•In one file, the member complained that she was unable to locate a PCP in her area and requested a list of PCPs. Humana attempted to reach the member by phone without success. Humana sent the member resolution letter 10 days after receipt without providing the member with a list of PCPs. *Quality Improvement Plan: Review processes and timeliness standards for grievances and implement steps for performance improvements.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are categorized, analyzed, and reported internally per policy and contractual requirements.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

IV. QUALITY IMPROVEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV. QUALITY IMPROVEMENT						
IV A. The Quality Improvement (QI) Program *42 CFR §438.330 (a)(b) and 42 CFR §457.1240(b)*						
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	X					The 2021 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description was submitted for review. The scope of work described in the program description includes areas such as preventive health, quality of services, over and underutilization, population health management, behavioral health, continuity and coordination of care, accessibility and availability of care, member and provider satisfaction and health outcomes. On an annual basis, the Quality Department reviews and revises as needed, the Quality Program Description. Humana makes information about its Quality Program available to members and practitioners.
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					
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of	X					Humana develops an annual work plan that specifies activities planned to assess the quality and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).						appropriateness of care furnished to members. The work plan is updated as needed and approved annually by the Quality Assurance Committee. The 2021 and 2022 QI Work Plans were provided for review. There were several goals that have not been determined throughout the 2022 Work Plan. *Recommendation: Determine the measurement goals for each activity on the 2022 Work Plan.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Humana's Quality Assurance Committee (QAC) is responsible for directing and reviewing quality improvement activities and taking appropriate actions as needed. Pages 15 - 25 of the QI Program Description include the Quality Committee Structure and a description of each committee. In the chart on page 15, the Pharmacy and Therapeutics Committee is not included, and a description of the Health Services Organization National UM Committee was not included in the program description. This was a recommendation from the Readiness Review that was not corrected. Humana's staff indicated during the onsite this had been corrected in the 2022 QI Program Description. The 2022 QI Program Description was provided following the onsite and corrections were made.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. The composition of the QI Committee reflects the membership required by the contract.		X				Humana's Medical Director serves as chair for the QAC. Members of the committee include senior staff department leads, directors, and managers. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. However, the membership list and committee minutes for this committee did not include any participating network practitioners. Humana indicated recruitment efforts are underway to recruit providers. *Quality Improvement Plan: Recruit a variety of participating network providers as members of the Quality Assurance Committee.*
3. The QI Committee meets at regular quarterly intervals.	X					The QAC meets at least quarterly, and a quorum has been defined as 50% of the voting members plus one. Voting members are expected to attend each meeting; in their absence proxy representation is required.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Committee minutes for meetings held in September 2021, November 2021, and February 2022 were provided. The minutes were very detailed and included extensive reports and discussions.
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."					X	Humana did not provide performance measures for validation. Per onsite discussion, Humana expects to have reported rates next year.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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	There were no projects submitted for validation. Per onsite discussion, the health plan is reviewing baseline data, other data sources, and forming work groups to begin the discussions regarding topics for performance improvement projects. *Recommendation: Continue the review of baseline data and convene work groups so topics for performance improvement projects can be developed.*
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."					X	Humana submitted the template they plan to use to document their performance improvement projects. The template included all required elements.
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 is that providers agree 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.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Humana uses the Stars Quality Report, which provides a list of members that have a known gap in care. The Stars Quality Report is delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.	X					Humana evaluates the effectiveness of the QI program and activities conducted in the previous year. Per Humana, with 2021/2022 being the first calendar year of operations, the QI program evaluation is scheduled to be completed in August 2022. The evaluation will address the accomplishments, analyze data and outcomes compared to goals, and include limitations or barriers to meet objectives. The program evaluation will be reviewed and approved by the Quality Assessment Committee and provided to Humana's internal board.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:	X					The 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. The daily oversight and operating authority of UM activities is delegated to the Medical Management Committee. Page 7 of the UM Program Description provides an overview of the responsibilities and requirements for this committee. Humana indicated due to limited data and medical monitoring metrics discussed in other meetings and committees, this committee was dismantled. The responsibilities of the Medical Management Committee were transferred to the Quality Assessment Committee. Also, page 5 incorrectly references the Plan Quality Assessment and Performance Improvement

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee. Humana does not have a committee titled "Quality Assessment and Performance Improvement Committee." *Recommendation: The UM Program Description should be updated to reflect the appropriate committee responsible for the oversight of the UM functions. Also, remove the references to the Quality Assessment and Performance Improvement Committee.*
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					
1.2 lines of responsibility and accountability;	X					Humana's Medical Director oversees all aspects of the UM Program. A registered pharmacist oversees the implementation, monitoring and directing of pharmacy services.
1.3 guidelines / standards to be used in making utilization management decisions;	X					The UM Program Description mentions the Plan uses the state specific Medicaid Coverage Manual, MCG, American Society of Addiction Medicine (ASAM), and Medical Coverage Policies for making UM decisions. Humana has developed a list of services that require prior authorization, and the website provides multiple resources and links for providers regarding the prior authorization process and what requires authorization. Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provide a summary of the process

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						used to manage the prior authorization list. Both policies contain basically the same information. Policy (Preauthorization List (PAL) Governance)-001 was watermarked "draft" and had an issue date of 2/25/2022. No explanation was provided regarding the purpose of both policies. *Recommendation: Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 to determine which policy best defines the process Humana uses to manage the Preauthorization List.*
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;		X				The timeliness for Utilization Management decisions is included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Requests for non-urgent standard authorizations are reviewed within 14 calendar days following receipt of the request for service. Urgent requests are authorizations are reviewed within 72 hours after receipt of the request. Focus Health, Inc. provides Behavioral Health Utilization Management Reviews. The Focus policy, Initial Case Review V 14.0, contained the timeframes for completing requests for peer reviews. This policy incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS MCO Policy and Procedure Guide, 4.2.24.* *Quality Improvement Plan: Correct the timeframes for completing non-expedited reviews and include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse treatments in the Focus policy, Initial Case Review V 14.0.*
1.5 consideration of new technology;	X					The Technology Assessment Forum of the Plan's Health Guidance Organization is responsible for developing the Plan's coverage decisions regarding emerging technologies.
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					Page 14 of the UM Program Description describes Humana's Preferred Provider Gold Carding Program. There are currently no providers that qualify for the Gold Carding Program.
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The UM Program Description describes the Chief Medical Officer/Medical Director's role and responsibilities. Humana's Medical Director oversees all aspects of the UM Program.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					The UM Program is evaluated at least annually, and modifications made as needed. The 2021 Utilization Management Program Evaluation will be completed in May 2022.
V B. Medical Necessity Determinations *42 CFR § 438.210(a-e),42 CFR § 440.230, 42 CFR § 438.114, 42 CFR § 457.1230 (d), 42 CFR § 457. 1228*						
1. Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations.	X					Humana uses MCG guidelines to determine medical necessity and appropriateness of physical health care and the Behavioral Health guidelines from the American Society of Addiction Medicine criteria. On an annual basis, an overview of the criteria is presented to the Quality Assessment Committee for approval. The overview includes discussion of key changes as well as any process changes. Staff are updated related to any changes in the criteria set as needed based on when changes occur. Providers are notified through the Provider Manual and adverse benefit determination letters of the criteria utilized for medical necessity determinations. Treating providers may, at any time, request UM criteria pertinent to a specific authorization by contacting Humana or may discuss the UM decision with the Medical Director.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					Providers are instructed via the Provider Manual of the requirements and consent forms needed for hysterectomies, sterilizations, and abortions.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.		X				Humana's UM Program Description provided a summary of the Inter-rater Reliability monitoring process used to assess consistent decision-making for all staff who render clinical determinations. The goal is an overall average score of 85% for physicians and 90% for non-physician reviewers. To date Humana has not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing. *Quality Improvement Plan: Conduct IRR testing for all staff who render clinical determinations.*
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.		X				The Pharmacy Program Description provides an overview and structure of Humana's pharmacy program. The Preferred Drug List (PDL) identifies formulary restrictions by indicating medications requiring prior approval, limitations, and/or step

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL. The *SCDHHS Contract*, *Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List (PDL) changes on Humana's website at least 30 days prior to implementation. Policy (Formulary Change Notification Process)-005, defines how Humana notifies affected parties of changes to the formulary. Notices for PDL changes were found on Humana's website; however, the effective date for the change and when the notice was published to the website were unclear. The notice contained a date at the top of the page without an explanation of what this date represents. *Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Humana's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					The UM Program Description discusses emergency services (page nine). However, does not include a description of post-stabilization services.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Include a description of post stabilization services in the UM Program Description.
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Humana has Utilization Management front line staff responsible for initial review of service authorization requests. Any decisions to deny a service authorization request is made by a licensed physician.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					The review of approval and denial files confirms Humana performs reviews using appropriate criteria with notification promptly communicated to provider and member, as applicable. UM files reflected use of appropriate criteria and appropriate attempts to obtain additional clinical information when needed to render a determination.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Denial decisions were made by an appropriate physician specialist. 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 are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.		X				Humana provided several letter templates for notifying providers and members of adverse benefit determinations. The Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days when requested by the member or by the plan. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation to the member for when to use this contact information. *Quality Improvement Plan: Correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.*
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner	X					Humana has several policies that describe appeals. Policy (South Carolina Medicaid Grievance and Appeal Policy) – 001 and policy (South Carolina Medicaid Grievance and Appeal Policy Draft)-001E

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
consistent with contract requirements, including:						only included the *SCDHHS Contract* references and did not specify Humana's process for handling appeals. The process for handling appeals is contained in Policy (South Carolina Medicaid Standard Appeal First Lever) – 001G, Policy (South Carolina Medicaid Expedited Appeal First Level) – 001B, and Policy (South Carolina Medicaid Fair Hearing External Second Level Review)-001D. Information on the appeal process was also found in the Member Handbook, the Provider Manual, and on Humana's website.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Humana resolves and provides notice of resolution within 30 calendar days of receipt for standard

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appeals and within 72 hours of receipt for expedited appeals, as noted in policies. If a request for expedited appeal is denied, the member is notified, and the appeal is processed within the standard 30-day timeframe.
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.		X				Humana provided one appeal file. The file reflected the acknowledgement and resolution was completed timely. An appropriate physician reviewed the file and made the decision to uphold the original denial. The resolution notice contained the following errors. •The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." •Also, the language used to describe why the denial was upheld appeared to be above the 6th grade reading level. *Quality Improvement Plan: Develop a process for monitoring resolution notices to ensure the letter*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						contains correct reviewer information and the language meets the SCDHHS 6th reading level.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Records of all appeals are monitored quarterly and presented to the Quality Assurance Committee. A review of committee minutes found appeal information was presented during the committee meetings and areas of concern noted.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					An overview of the Care Management (CM) Program is found in the Care Management Program Description. The CM Program Description defines the goals of the program and addresses criteria for enrollment in CM, methods and processes for enrollee identification and assessment, and management and evaluation of enrollee care and outcomes. The Care Management Program Description does not describe the structure of the program. Additional Standard Operating Procedure (SOP) documents were provided that contain information and instruction for staff about conducting case management functions and activities. These include SOPs for general care management, pediatric care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						management, and care management for the Moms First program. *Recommendation: Revise the Care Management Program Description to include the program's structure, to include departmental oversight, leadership, staffing positions, etc.*
2. The MCO has processes to identify members who may benefit from care management.	X					According to the CM Program Description, Humana receives CM referrals via various forums, such as referrals from state agencies, internal referrals (Enrollee Services, Utilization Management), Health Risk Assessments (HRA), eligibility files, community organization referrals (local shelters, food banks, etc.), provider or member/caregiver self-referrals, etc. Humana uses predictive modeling and data analysis to stratify members by risk and identify enrollees who are potential candidates for CM services using. Data sources include, but are not limited to: •Enrollment information and demographics •Utilization patterns and UM data (•Diagnosis and CPT codes •Claims and encounters •Major clinical conditions •Behavioral health conditions •Medications/pharmacy benefit use •Labs •Utilization

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides care management activities based on the member's risk stratification.	X					The Care Management Program Description defines processes to stratify members into risk levels based on member demographics, claims, ED utilization, admissions, and medical history information obtained from assessments or other sources, such as the Heath Risk Assessment (HRA). Humana's stratification levels include: •Complex Care Management for members with the highest needs who require the focused attention to support clinical care needs & social determinants of health (SDOH). •Intensive Care Management for members at high risk but who do not meet criteria for Complex Care Management and who require intensive, highly focused attention to support clinical care needs & SDOH. •Care Management-Moderate Risk for members who don't meet criteria for Intensive or Complex Care Management and have rising risk and require focused attention to support clinical care needs and SDOH. •Care Management-Low Risk for members who require prevention support and wellness messaging specific to their condition(s) and who do not meet the requirement for any other level of care management. Additionally, Humana offers care management to all enrollees with Special Health Care Needs (SHCN)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						regardless of information gathered through the comprehensive assessment, the HRA, or predictive modeling. Enrollees with SHCN are members with ongoing special conditions that require a course of treatment or regular care monitoring.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. Care Transitions activities include all contractually required components.						
5.1 The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy (UM-COC Policy)-008, Continuity of Care and Care Transitions, defines continuity of care activities and provides guidance for handling care transitions when members transfer into Humana Medicaid or from another MCO, members who disenroll from Humana and transfer to another MCO or Medicaid, and members whose provider is terminated from the Humana network.
5.2 The MCO has a designated Transition Coordinator who meets contract requirements.	X					
6. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					The Care Management Program Description includes information about conducting an annual evaluation of the Care Management Program to determine opportunities for improvement and to inform revisions to the program. The Care Management

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Program evaluation is conducted by the Director of Health Services, and considers key metrics such as population needs, clinical outcomes, and member experience results from complex case management/disease management satisfaction surveys and CAHPS surveys. The program description does not provide detailed information about conducting satisfaction surveys with members who have been enrolled in the complex case management/disease management programs. Onsite discussion revealed Humana conducts these annually to assess member satisfaction with the programs. *Recommendation: Revise the Care Management Program Description to include detailed information about the processes for assessing member satisfaction specific to the Care Management Program. The information should include methods of survey, members who will be included, processes for conducting the survey, and processes for evaluating and reporting results of the survey.*
7. Care management and coordination activities are conducted as required.	X					Case Management files reflected that staff document the member's consent for participation in Case Management activities. Documentation confirmed staff consistently evaluate member needs, refer members to available community resources, assist with scheduling visits with providers

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						and transportation for appointments, and address identified needs in the care plans.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.		X				Policies for drug utilization, the Utilization Management Data Plan and the Fraud, Research, Analytics and Concepts report for fraud management was submitted. The utilization management data plan offered some utilization indicators that will be monitored, including acute admits per 1000, inpatient days per 1000, readmission rates, ER visits per 1000 and others. All monitoring and assessment will be done by the Medical Management team and shared with Quality Management team. There was not a specific policy or action steps planned for addressing over and underutilization. This was an issue identified during the Readiness Review. In response to this deficiency, the Utilization Management Data Plan stated that the Medical Management Committee "creates plans to mitigate when issues are identified." However, the process for how that is conducted was not clearly documented. The During the onsite, staff indicated the Utilization Management Team was still building this out. *Quality Improvement Plan: Provide more detail in the Utilization Management Data Plan regarding*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						issues identified during the monitoring of over or underutilization. The data plan should include steps If monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.
2. The MCO monitors and analyzes utilization data for over and under utilization.					X	

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					Policy (Delegation)-001 describes Humana's process for conducting pre-assessments of potential delegates' abilities to perform the selected delegated functions in compliance with contractual, regulatory, accreditation, and health plan standards and requirements. The pre-delegation audits evaluate policies, procedures, program descriptions, work plans, forms, tools and reports; accreditation; file audits if applicable; and processes for monitoring federal/state exclusion screenings. Once the delegation is approved, a written Delegation Services Addendum and Delegation Attachment are executed These documents serve as a written delegation agreement and specify the activities delegated, the responsibilities for both the delegated entity and Humana, requirements for complying with Humana, state and federal law and accreditation organization requirements, processes for evaluating performance, and actions that may result of the delegate does not fulfill its obligations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The 2021 Subcontractor Monitoring and Oversight Plan provides an overview of delegate selection, oversight, and annual auding processes. Policy (Delegation)-001, Delegation Policy, describes Humana's process to conduct annual delegation audits to review delegated entities against contractual, state, federal, accreditation, and health plan standards and requirements to ensure compliance. The Delegation Compliance Department conducts these annual delegation audits. Results are recorded on a standardized audit tool. The Delegation Compliance Department conducts ongoing monitoring of all delegates through required delegate reporting and routine Joint Operations Committee meetings (JOCs). Performance summaries are provided to other teams, including South Carolina market leadership and quality oversight. Policy(CORE Credentialing and Recredentialing)-001 addresses delegated credentialing requirements. Delegates are required to follow the NCQA credentialing and recredentialing standards and SCDHHS Contract requirements. The Credentialing Annual Audit Tool includes all required elements for initial credentialing and recredentialing. It was noted that column "BH" of the "Medicaid Reviews" tab of the tool lists both the SC Excluded Providers List and the SC Terminated for

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Cause List. This was discussed with Humana staff during the onsite and staff confirmed they ensure the delegates are querying both. CCME's review of the annual oversight documentation submitted by Humana revealed annual oversight is conducted for each of the delegated entities, and appropriate recommendations and corrective actions are issued when warranted as a result of annual oversight and ongoing monitoring. *Recommendation: List the SC Excluded Providers List and the SC Terminated for Cause List in separate columns on the "Medicaid Reviews" tab of the Credentialing Annual Audit Tool so that it is clear the delegates are querying both of these required lists.*

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						Policy (NNO 702-040 Physician Performance Measurement) – 007 describes Humana's methodology for evaluating provider performance. For South Carolina Medicaid, several resources are to obtain provider data including, Software – OptumTM Symmetry® EBM Connects, and Quest Analytics Suite. Onsite discussion revealed Humana will run a Stars Quality Report monthly that will display gaps in care. This report will be given to providers and providers will be able to access the information "on-demand" via the provider portal. Examples of reporting documents that will be used were provided. A policy and/or procedure was not identified describing processes for monitoring provider compliance specific to administering immunizations and performing EPSDT or well-care services for members.
1.1 administering required immunizations;			X			Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Implement activities to track provider compliance with administering required immunizations.
1.2 performing EPSDTs/Well Care.			X			Humana presented no evidence that it is currently tracking provider compliance with performing EPSDT/Well Care services. Additionally, the *SCDHHS Contract, Section 4.2.10.1* states MCOs must "Have written Policies and Procedures consistent with *42 CFR 441, Subpart B*, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults." *Quality Improvement Plan: Develop a written policy and procedure for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible members. Implement activities to track provider compliance with performing EPSDT/well care services for members.*
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			Humana did not implement the Quality Improvement Plans corrections to address the following deficiencies identified during the 2021 Readiness Review:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						•Action was not taken to ensure credentialing and recredentialing files include full collaborative agreements between nurse practitioners and their supervising/collaborating physician. •Action was not taken to ensure letters notifying providers of credentialing and recredentialing determinations are dated on or after the date of the credentialing/recredentialing determination. •There was not a specific policy or action steps planned for addressing the monitoring of over- and under-utilization. *Quality Improvement Plan: Address and implement actions to correct all identified deficiencies.*