Constellation Quality Health

Humana Healthy Horizons in South Carolina

2024 EXTERNAL QUALITY REIVEW

Submitted: March 7, 2024

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

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires State Medicaid Agencies that contract with Managed Care Organizations (MCOs) to evaluate their compliance with state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. This report contains a description of the process and the results of the 2024 External Quality Review (EQR) that Constellation Quality Health, formerly 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 in South Carolina (Humana) since the 2023 Annual 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 2023 annual EQR and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Validate contracted health care services are being delivered.

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

Summary and Overall Findings

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

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

- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection (§ 438.214, § 457.1233)
- Confidentiality *(§ 438.224)*
- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- Sub-contractual Relationships and Delegation *(§ 438.230, § 457.1233)*
- Practice Guidelines (§ 438.236, § 457.1233)
- Health Information Systems *(§ 438.242, § 457.1233)*
- Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*

To assess Humana's compliance with the 14 *Subpart D* and QAPI standards as related to quality, timeliness, and access to care, Constellation Quality Health'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 follows appropriate processes to develop and implement policies to guide health plan operations. Staff are educated about new and revised policies and may access them on the policy management platform or a SharePoint site. All key positions are filled except for the Member Services Manager position. This is the second consecutive year Humana has not met the contractual requirements for this position. No other staffing issues were noted.

The Corporate Compliance Plan, the Special Investigations Unit Anti-Fraud Plan, and related policies and procedures describe processes to comply with contractual, state, and federal requirements and to monitor, detect, prevent, and investigate fraud, waste, and abuse (FWA). The code of conduct addresses expectations for employee conduct and ways to report compliance issues and FWA. Compliance training is mandatory at employment and annually. Various policies appropriately address required exclusion and sanction screenings; however, the 2023 Subcontractor Monitoring and Oversight Plan does not address all required screenings.

The Corporate Compliance Committee, chaired by the corporate Chief Compliance Officer, is the decision-making authority for all compliance matters. Issues that may affect SC are identified and discussed during Medicaid Compliance Steering Committee meetings. Humana staff reported that a SC Compliance Committee is being established, will be chaired by the SC Compliance Officer, and will begin meeting by the end of Q1 2024.

Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, does not address all contractually required program elements and does not clearly address the process followed when a member appeals the decision to include the member into the program.

Humana focuses on maintaining the integrity and security of its data and information systems and adheres to security best practices as documented in policies and procedures. Comprehensive processes are in place to mitigate business interruptions and reestablish operations. Humana conducts regular security audits and disaster recovery tests.

Provider Services

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

Credentialing processes and requirements are appropriately documented in health plan policy and the 2023 Healthy Horizons in South Carolina CORE Credentialing & Recredentialing Program Description. The Credentials Committee, chaired by a Medical Director, meets monthly to make credentialing decisions. Voting members include network providers specializing in family medicine, internal medicine, obstetrics and gynecology, and psychiatry, as well as a pharmacist and nurse practitioner. Humana reported that attempts to recruit additional specialty providers have been unsuccessful. Issues noted in the review of initial credentialing files for practitioners were related to verification of admitting privileges and Clinical Laboratory Improvement Amendments (CLIA) certification, and collection of nurse practitioner collaborative agreements.

Appropriate processes are in place for initial and ongoing provider education. Ongoing education is provided through a variety of forums, and Humana holds Town Halls in several locations throughout the state each year. Humana adopts and educates providers about clinical practice and preventive health guidelines, coordination of care, and medical record documentation standards, and assesses provider compliance.

Constellation Quality Health conducted a validation review of Humana's provider network following the CMS protocol titled, "EQR Protocol 4: Validation of Network Adequacy." Constellation Quality Health also conducted a Telephone Access Study. Humana met the requirements of the Network Adequacy Validation. The 2023 Humana Healthy Horizons® in South Carolina Annual Network Development Plan provides an overview of the plan to maintain and grow the SC provider network. To assess network adequacy, Humana uses appropriate geographic access standards and considers member satisfaction survey results, analysis of complaints, etc. Processes have been established to address any identified geographic access gaps. Health plan policy appropriately documents appointment access standards, and provider compliance is assessed through satisfaction surveys, member complaints, annual Provider Access and Availability Surveys, and out-of-network requests. Appropriate action is taken to address non-compliance.

The online "find a doctor" tool and printed Provider Directories include all contractually required elements, with the exception that the online "find a doctor" tool did not include the statement that some providers may choose not to perform certain services based on religious or moral beliefs.

Humana has implemented a Culturally and Linguistically Appropriate Services program, and recently achieved Health Equity Accreditation from NCQA. Cultural competence information and resources are available to providers in the Provider Manual and on the website.

For the provider access study conducted by Constellation Quality Health, the successful answer rate was 77%, an increase from the previous year's rate of 57%. The compliance rate for routine appointment availability was 83%.

Member Services

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

Humana's QuickStart Guide, Member Handbook, Provider Manual, and website summarize member rights and responsibilities. Welcome kits include member educational materials and are sent to new members no later than 14 calendar days from receipt of enrollment data. The Member Handbook provides information members need to understand benefits, services, and health plan processes. Members are notified in writing 30 days before the effective date of changes to services and benefits.

Humana provides member materials in alternate languages and formats and instructs members about how to request these materials. The availability of member materials is emphasized for members in the Annual Benefits Letter.

The Customer Service number and hours of operation are provided throughout the Member Handbook and website. The Nurse Advice Line is available to members 24/7. Policy SC.MCC.008, Disenrollment Requests, describes Humana's process for requesting disenrollment.

Member Satisfaction Survey: Humana contracts with Press Ganey to conduct the member satisfaction surveys. For MY2022, adult response rate was 12.6%, an improvement from the previous year's response rate of 5.1%. For year over year trending, improvement was demonstrated in rating of health plan, rating of health care, and flu vaccine. The largest decline was for getting care quickly. The child response rate was 6.8%, a decline over last year's rate of 7.9%. Improvement occurred for rating of health plan, getting needed care, customer service, rating of health care, getting care quickly, and how well doctors communicate. The largest decline was noted for the rating of specialists. The child CCC response rate was 6%, an improvement over the previous year's rate of 5.4%. For the CCC population, the highest rated domain was getting care

quickly. The improvement and decline evaluation are not performed due to a reported sample size of zero for several domains last year.

Processes for filing and handling grievances are detailed in policies, the Member Handbook, the Provider Manual, and on Humana's website. Explanations were provided about grievance acknowledgment, resolution, and extensions. Grievances are logged and categorized appropriately. Trends are reported quarterly as reflected in the minutes of the Quality Assurance Committee.

Of the sample of grievance files reviewed, the majority were acknowledged and resolved timely. However, three grievance files were closed with significant time remaining, and members were instructed to contact the MCO to provide further information. One grievance was closed significantly beyond the 90-day resolution timeframe. Humana staff explained that coaching and additional trainings were provided to the reviewers assigned to these grievances.

Quality Improvement

42CFR §438.330, 42 CFR §457.1240 (b)

Humana's Quality Improvement (QI) Program's focus is to monitor, evaluate, and facilitate improvement in the quality of health care services provided to members. The 2023 Quality Assessment and Performance Improvement Program Description describes the QI Program that Humana has implemented to help achieve the goals that are outlined in the document.

Humana develops a work plan annually that includes measurable goals and objectives based on the previous year's annual evaluation. The 2022 and 2023 QI Work Plans were provided. The work plans included the quality improvement activities, the goals and objectives for each activity, the responsible party, and the expected completion date. The work plans lacked details regarding any updates or changes when reports were not presented to the applicable committee. Some goals noted in the work plans were not the goals that were reported.

The Quality Assurance Committee (QAC) is the local committee responsible for providing operational oversight of the QI program. The 2023 Quality Assurance Committee Charter provided an overview of the committee's purpose, membership, responsibilities, meeting requirements, and reporting. This committee is chaired by the Chief Medical Officer and co-chaired by the Quality Improvement Lead. Other members of the committee include directors and other representatives from the health plan's management staff.

The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. The committee meeting minutes demonstrated Humana lacked a variety of participating network providers on this committee. This was an issue identified during the previous EQR and not corrected. Minutes are documented for each meeting and presented to the committee for review and approval at the next scheduled

meeting. The QAC 2023 Charter indicates a quorum of fifty present of the voting members plus one must be present for committee action and voting members are expected to attend each meeting or appoint a representative in their absence. The committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings.

After the onsite, Humana submitted another copy of the QAC meeting minutes for meetings held in 2023. It was noted for the August 2023 meeting the voting members' attendance had changed. There was no documentation indicating why the attendance was changed and the minutes amended.

Humana requires providers to actively participate in QI activities. Provider performance is shared via the Stars Quality Report and primary care providers can participate in the Primary Care Provider Recognition Program.

At least annually, Humana assesses the effectiveness of their quality program. Last year Humana provided the 2021 – 2022 QI Program Evaluation. This evaluation lacked the results and analysis for some of the activities, and there were errors noted for some of the goals. Constellation Quality Health found the previously identified issues were not corrected in the evaluation received for this EQR. There were issues with missing data or results and incorrect goals being measured.

Performance Measure Validation: Humana produces HEDIS rates using software from an NCQA-certified measure vendor. The performance measure validation found that Humana was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures (PMs) for the current measure year (2022) and the previous measure year (2021) are reported in the QI section of this report. Due to all rates having at least one measurement year of unreliable rates with denominators less than 30, percentage point differences are not reported.

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

For this review, Humana submitted two PIPs. Topics for those PIPs included the Human Papillomavirus Vaccine (HPV) and the Prenatal and Postpartum PIP. Both PIPs scored in the "High Confidence in Reported Results" range as noted in the tables that follow. A summary of each PIP's status and interventions is also included.

Table 1: Human Papillomavirus Vaccine PIP

Human Papillomavirus Vaccine (HPV)	
The HPV vaccine PIP is aimed at increasing HPV vaccines among 9–13-year-olds. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the human papillomavirus (HPV) vaccines. The goal rate for this PIP is 36.5%. Measure Year (MY) 2021 rate was 1.82% which improved to 3.85% for MY 2022 for the interim rate, with a final rate of 11.5%. This rate includes medical record, supplemental, and administrative data.	
Previous Validation Score	Current Validation Score
79/79=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• HEDIS metric monitoring dashboard to include data monitoring and tracking towards goals. • Clinical dashboard with HEDIS alerts to prompt Case Management staff to educate members on missing preventative services, including vaccines. • Targeted outreach campaigns specific to EPSDT program offerings. • Well child visit text campaign to support well-child visits with an effort to increase chances of positive provider-member relationship. • Member and Provider newsletters educating providers on HPV vaccine uptake importance. • Member Incentives • Provider Newsletter education related to same day, same way campaign.	

Table 2: Prenatal and Postpartum PIP

Prenatal and Postpartum (PPC)	
The aim for the Prenatal and Postpartum PIP is to increase the rate of eligible women receiving timely prenatal and postpartum care. The purpose of this project is to align with state efforts of increasing postpartum compliance in South Carolina by 15% by 2026. There were low denominators for the baseline rates for MY 2021, with a rate of 100% for prenatal care (only 3 members included in the rate) and 0% for postpartum care (3 members in the rate). For MY 2022 interim rates, the results showed 84.49% for prenatal care (goal is 85.4%) and 57.59% (goal is 77.37%) for postpartum care. The final HEDIS rate is noted, however, as 92.7% for prenatal care, and 72.06% for postpartum care. The final MY 2022 rates show that prenatal care is above the goal, and the final rate for postpartum is below the goal but improving.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Prenatal and Postpartum (PPC)
• Implemented Case Management staffing structure to include a bi-lingual prenatal nurse and reminders. • Data monitoring through Cotiviti at a monthly cadence. • Targeted outreach campaigns specific to Humana Beginnings program offerings. • Provider newsletter educating providers on 12-month postpartum extended coverage. • Value Added Benefits for pregnant members that included car seats and cribs.

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's Utilization Management (UM) Program Description and various policies outline the scope, objective, and staff responsibilities within the UM program for behavioral health and physical health services. Pharmaceutical services provided to members are described in the Pharmacy Program Description and various policies. Humana's Chief Medical Officer, a senior level physician, provides overall oversight and management of the UM program. The Behavioral Health Director and Pharmacy Director provide oversight in their respective programs and support to the Chief Medical Officer.

Initial clinical reviews are conducted by approved licensed clinicians within their respective healthcare disciplines using approved clinical coverage criteria. The Clinical Intake Team provides support for non-clinical activities for the UM department.

The UM determinations are based on the appropriateness of care and do not reward practitioners, or anyone involved in the UM process for issuing adverse benefit determinations. Humana conducts annual Inter-rater Reliability (IRR) testing for all staff and based upon the IRR results, the Medical Directors and UM reviewers received a passing score.

Constellation Quality Health's review of a sample of approval files demonstrated consistency in utilizing evidenced based criteria and reviews were conducted by appropriately trained staff. The review of a sample of adverse benefit determinations demonstrated that the determinations were promptly communicated to the provider and member. However, the determination letters in the file sample and the adverse benefit determination letter templates incorrectly informed members that a written appeal is required when an oral request is submitted.

Humana's policies detail processes for filing and handling member appeals. These processes are consistently reflected in the Provider Manual, Member Handbook, and on Humana's website. Appeal terminology is defined as are processes for filing member standard and expedited appeals.

SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not address the requirement that members may file a grievance

if they disagree with an extension of the appeal resolution timeframe. Appeals are logged and categorized appropriately, monitored for trends, and reported quarterly as reflected in Quality Assurance Committee minutes.

A sample of appeal files was reviewed. All the files were processed timely and included documentation of the review by an appropriately credentialed reviewer. The file review reflected that previously identified issues were addressed.

An overview of the Care Management (CM) Program that entails the care management and care transitions process is found in the Care Management Program Description and various policies. Members are identified for care management through various referral sources. Based upon completion of the Health Risk Assessment, members are provided care management activities appropriate to their risk level and specialized programs are offered for members with specific identified needs. Transition of care services are provided for members. The policy that addresses continuity of care did not address continuity of care while a member is in the appeals process.

An annual review of the Care Management Program is conducted to assess quality of care and identify any gaps in care.

Review of the sample care management files yielded that care management activities were conducted according to contractual requirements.

Delegation

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

Humana delegates to subcontractors and/or vendors to perform some health plan activities, including some utilization management services, translation services, non-emergency transportation, credentialing, health risk assessments, nurse advice line, health coaching, and other services. For this EQR, Humana reported 14 subcontractors and/or vendors. Policy SC.DCO.001 includes the specific requirements for sub-delegation. Delegates are required to request approval from Humana to sub-delegate any portion of the delegated functions or activities. However, this policy does not include the requirement to notify SCDHHS of any further delegation by a subcontractor (*SCDHHS Contract, Section 2.5.11*).

Humana provided copies of the annual delegation oversight monitoring. Some of the elements on the audit tools used for the file review were not scored appropriately during the annual audits.

Mental Health Parity

Constellation Quality Health is required to conduct a Mental Health Parity assessment to determine if Humana meets the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment is conducted as a two-step process. Step one involves assessing the

quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits.

Constellation Quality Health reviewed Humana's supporting documents to assess both elements of NQTL Parity: comparability and stringency. Humana has the tools, plans, and interventions to support the goal of Parity. The NQTL assessment found the mental health services comply with Parity requirements of comparability and stringency.

Two templates were provided to Humana to complete for the QTL mental health parity assessment. The templates allow the plan to enter information based on copay, session limits, day limits, etc. This information was used to determine if financial requirements and quantitative treatment limitations that apply to mental health and substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical benefits. The files submitted demonstrated a copay for prescriptions and no limits or copay for inpatient or outpatient services. The $3.40 copay applied to prescriptions is consistent for medical surgical and behavioral health. Thus, the findings show appropriate parity for mental health services in relation to medical services.

Quality Improvement Plans and Recommendations from Previous EQR

During the previous EQR, there were ten standards scored as "Partially Met" and eight standards scored as "Not Met." The following is a high-level summary of those deficiencies:

- Constellation Quality Health noted continued issues with health plan policies.
- It was unclear who fulfills the requirements of the *SCDHHS Contract, Section 2* for the key positions of Administrator (CEO, COO, Executive Director, etc.), Provider Services Manager, and Member Services Manager.
- The Organizational Chart did not display the operational relationships for key areas, and operational relationships of staff were not clearly and consistently documented across the Staffing Lists and Key Personnel Lists.
- The PDF versions of the Provider Directories included contradictory information about how to locate providers who are accepting new patients.
- The PDF versions of Humana's Provider Directories did not include an indication of providers that are not accepting new patients, as required by the *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR 438.10 (h) (1) (vi)*.

- Policy SC.NNO.007, Provider Orientation and Annual Training, is not specific to SC and referenced provider orientation materials that were not being used.
- No information was identified in the Provider Manual regarding reassignment of a member to a different PCP.
- Policy SC.MCC.008, Disenrollment, incorrectly stated members must file a grievance with the health plan in order to request disenrollment.
- Policy SC.GAA.001, the Member Handbook, and Humana's website use outdated terminology to define a grievance.
- The QI Program description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships).
- The Quality Assessment Committee lacked a variety of participating network practitioners as required by SCDHHS Contract.
- The 2021 – 2022 QI Evaluation lacked the results and analysis for some activities:
- The 2023 Utilization Management Program Description contained errors regarding the committee responsible for oversight, monitoring, and direction of the UM Program.
- The name of Humana's Pharmacy Benefits Manager was inconsistently documented in the Pharmacy Program Description, the UM Program Description and Humana's website.
- Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 contained basically the same information, were watermarked as "draft," and contained tracked changes. No explanation was provided regarding the purpose of both policies.
- The Pharmacy Program Description, Member Handbook, Provider Manual, and health plan policy did not address processes to meet requirements for provision of a 72-hour emergency supply of medication.
- Deficiencies were noted in the sample of appeal files regarding who made the appeal decisions, use of complex medical language, failure to meet appeal resolution timeframes, and use of incorrect criteria.

During the current EQR, Constellation Quality Health assessed the degree to which the health plan implemented the actions to address these deficiencies and found:

- For the second consecutive year, the Member Services Manager position is out of compliance with contractual requirements.
- The Quality Assurance Committee lacked a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*.

- The errors regarding missing data or results and incorrect goals being measured were not corrected in the QI Program Evaluation provided for this EQR.

Conclusions

Humana met eight 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 3: 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 14 Subpart D and QAPI standards above.

Table 3: Compliance Review Results for Part 438 Subpart D and QAPI Standards

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Disenrollment Requirements and Limitations *(§ 438.56)*	Member Services, Section III. C	1	1	100%
• Enrollee Rights Requirements *(§ 438.100)*	Member Services, Section III. A	2	2	100%
• Emergency and Post-Stabilization Services *(§ 438.114)*	Utilization Management, Section V. B	1	1	100%
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	12	11	92%
• Coordination and Continuity of Care *(§ 438.208, § 457.1230)*	Utilization Management, Section V. D	9	9	100%
• Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*	Utilization Management, Section V. B	14	14	100%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	41	40	98%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and	20	17	85%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
	Utilization Management, Section V. C			
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	1	50%
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D	9	9	100%
• Health Information Systems *(§ 438.242, § 457.1233)*	Administration, Section I. C	7	7	100%
• Quality Assessment and Performance Improvement Program *(§ 438.330, § 457.1240)*	Quality Improvement	16	12	75%

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

As noted in the table above:

- The online "find a doctor" tool did not include the contractually required statement that some providers may choose not to perform certain services based on religious or moral beliefs.
- Two of the three initial credentialing files for nurse practitioners did not include the collaborative agreement between the nurse practitioner and the collaborating physician.
- The grievance and appeal issues included the following:
  - Policy SC.MCC.005, Member Grievances and Appeals, and Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, did not indicate that members are informed that a letter will be sent within five (5) business days from the date of the receipt of a grievance.
  - Three grievance files were closed with significant time remaining, with resolution instructions for the member to make a return call to provide further information.
  - The determination letters incorrectly informed the member that a written appeal is required when an oral request is submitted.
  - Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not indicate that a grievance can be filed if the filer disagrees with the request for an extension of 14 days.
- Humana's delegation policy did not meet the requirements for sub-delegation, and the credentialing and recredentialing audits did not include all required elements.
- There were four standards that did not meet all requirements related to the quality work plans, quality committee members and minutes, and the QI program evaluation.

Table 4: Scoring Overview, provides an overview of the scoring of the current annual review as compared to the findings of the 2023 review. For Humana, 206 out of 219 standards received a score of "Met." There were 10 standards scored as "Partially Met," and three standards received a "Not Met" score.

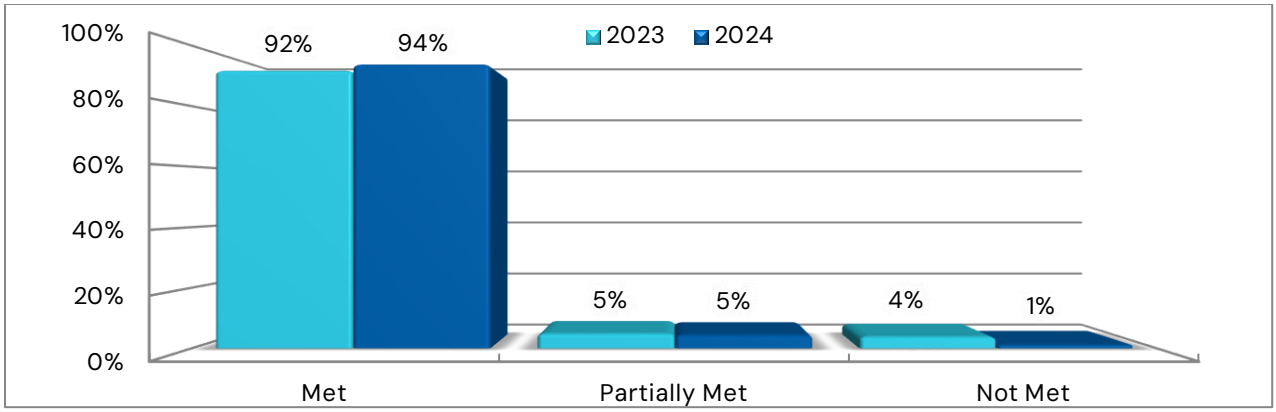
Table 4: Scoring Overview

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2023	35	2	3	0	0	40	88%
2024	38	1	1	0	0	40	95%
Provider Services							
2023	73	2	1	0	0	76	96%
2024	78	1	1	0	0	80	98%
Member Services							
2023	31	1	1	0	0	33	94%
2024	31	2	0	0	0	33	94%
Quality Improvement							
2023	11	2	1	0	0	14	79%
2024	12	3	1	0	0	16	75%
Utilization Management							
2023	42	3	1	0	0	46	91%
2024	44	2	0	0	0	46	96%
Delegation							
2023	2	0	0	0	0	2	100%
2024	1	1	0	0	0	2	50%
Mental Health Parity							
2024	2	0	0	0	0	2	100%
Totals							
2023	197	10	8	0	0	215	92%
2024	206	10	3	0	0	219	94%

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

The 2024 Annual EQR shows that Humana achieved "Met" scores for 94% of the standards reviewed as the following chart indicates. This chart provides a comparison of the current review results to the 2023 review results.

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Recommendations and Opportunities for Improvements

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

Table 5: Evaluation of Quality, Timeliness, and Access to Care

Strengths	Quality	Timeliness	Access to Care
Administration			
Humana has revised policies and procedures to use a standard policy template that specifies a policy name and number.	✓		
The Organizational Chart displays operational relationships for key areas and indicates key personnel, staff for the South Carolina market, shared services, and vacant positions.	✓		
Humana has a focus on implementing and maintaining security measures that adhere to data security standards.	✓		
Humana has a robust infrastructure to replicate data and prevent data loss should an outage or incident occur.	✓		
Information systems documentation is regularly reviewed and updated as indicated by timestamps and change logs.	✓		
The Corporate Compliance Plan and Special Investigations Unit Anti-Fraud Plan address the Compliance Program and activities to prevent, detect, and respond to fraud, waste, and abuse. Related policies and procedures provide additional information about compliance and FWA detection and prevention activities.	✓		
The Ethics Every Day (code of conduct) is comprehensive and addresses expectations for ethical business conduct and practices.	✓		
Humana investigates alleged or suspected noncompliance and illegal/improper activities to determine and takes immediate action to address confirmed violations.	✓		
Policies, the Corporate Compliance Plan, and Ethics Every Day address confidentiality of member information and other protected information.	✓		

Strengths	Quality	Timeliness	Access to Care
Provider Services			
Credentialing processes and requirements are appropriately documented in policies and program descriptions.	✓		
Humana contracts with all required Status 1 provider types.			✓
No issues were noted in recredentialing files for practitioners and initial credentialing and recredentialing files for organizational providers.	✓		
Appropriate processes are in place to suspend or terminate network participation when serious quality of care or service issues are confirmed.			✓
Humana uses appropriate time and distance standards for network providers, as documented in Policy SC.NNO.004, Provider Network Availability and Access, and in the 2023 Network Development Plan.			✓
When assessing network adequacy, Humana considers geographic access, member satisfaction survey results, analysis of complaints, etc.			✓
Humana has implemented a Culturally and Linguistically Appropriate Services program and educates providers about the program. Cultural competency resources are available on Humana's website.			✓
Humana achieved Health Equity Accreditation in November 2023.	✓		
Annually, Humana conducts a Provider Access and Availability Survey to assess provider compliance with appointment access standards.			✓
The successful call rate for the provider access study conducted by Constellation Quality Health improved from the previous year.			✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
Humana communicates preventive health and clinical practice guidelines to providers and assesses compliance with the guidelines.	✓		
Provider compliance with medical record documentation standards is assessed through medical record audits.	✓		
Member Services			
Revisions and expanded information provided in the Member Handbook have strengthened this member resource.	✓		
Of the grievance files reviewed for the current EQR, all grievances were acknowledged timely, and the majority of the grievances were resolved timely.		✓	
Quality Improvement			
Humana shares results of provider performance with the Stars Quality Report and the Primary Care Provider Recognition Program Report.	✓		
Plan uses certified software for HEDIS calculations.	✓		
Both PIPs scored in the High Confidence range.	✓		
Utilization Management			
Humana exceeded the target monthly goal of 95% for processing behavioral health and medical service authorization requests.		✓	
Review of the sample approval files yielded that files were completed timely and completed by appropriately licensed professionals.		✓	
The IRR goal of 90% or higher for the Medical Directors and UM reviewers were met with the average score of 98.3%.	✓		

Strengths	Quality	Timeliness	Access to Care
Of the appeals files reviewed for this EQR, all were addressed timely and were reviewed by appropriately credentialed staff.		✓	
The Appeals section of the Member Handbook describes steps for a member to file an appeal, including instructions for submitting an oral appeal, obtaining forms for submitting an appeal in writing, and the online submission process.			✓
Appeal acknowledgement and resolution letters were clear with appropriate information needed specific to determination or next steps as applicable.	✓		
Delegation			
Humana measures compliance and performance of all delegated vendors.	✓		
Mental Health Parity			
Mental Health Parity was demonstrated in assessment of co-pays and financial limitations.			✓
The Mental Health Parity assessment showed mental health services are aligned with medical/surgical financial and treatment limitations.			✓
Access and availability parity is achieved; Provider Network analysis and implementation plans are robust and responsive down to the local level.			✓
Utilization Management criteria and processes achieve parity.			✓
IRR incorporates both MH/SUD and Medical/Surgical cases.	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Administration				
Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, includes multiple references to the term "policy owner;" however, it includes one reference to "business owner." Onsite discussion confirmed these terms are synonymous.	*Recommendation: Revise Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, to use either "policy owner" or "business owner."*	✓		
The 2023 Subcontractor Monitoring and Oversight Plan does not address requirements for checking the SSDMF, LEIE, the SC List of Excluded Providers, or the SC List of Providers Terminated for Cause.	*Recommendation: Revise the 2023 Subcontractor Monitoring and Oversight Plan to include all required queries for each subcontractor. Refer to the SCDHHS Contract, Section 11.2.10.*			✓
Issues noted with Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, include: • Page two states, "If the member files an appeal, they will be granted a stay of action and removed from the lock in program." Onsite discussion revealed	*Quality Improvement Plan: Revise Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, to include:* • *Full information about the process followed when members appeal inclusion in the lock-in program.*			✓

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
that the member is only removed from the program until the appeal determination is made. • The policy does not reference the 72-hour limitation on the emergency supply of medication included in the override. Refer to the *SCDHHS Contract, Section 11.10.3.5*. • The policy does not address the process for notifying members when the lock-in restriction is removed, as required by the *SCDHHS Contract, Section 11.10.5*.	• *The limitation of 72 hours for emergency supply of medication.* • *The process for notifying members when they are removed from the lock-in program.*			
Provider Services				
During the previous EQR, it was recommended that Humana attempt to recruit additional specialty providers to serve on the Credentials Committee. During the current EQR, Humana reported that recruitment activities continue but have thus far been unsuccessful.	*Recommendation: Continue efforts to recruit specialty providers to serve on the Credentials Committee.*	✓		
The following issues were noted in the initial credentialing files: • One file was missing documentation of verification of admitting privileges or arrangements. • One file was missing documentation of verification of CLIA certification. • Two of the three initial credentialing files for nurse practitioners did not include the collaborative agreement between the nurse practitioner and the collaborating physician.	*Recommendation: Ensure all applicable practitioner credentialing files include verification of admitting privileges or arrangements and verification of CLIA certification.* *Quality Improvement Plan: Collect collaborative agreements for nurse practitioners at initial credentialing and include in the credentialing file.*			✓
The following issues were noted in the 2023 Network Development Plan: • Page 5 includes "Prior Year Network Analysis" but the first paragraph under the heading states, "In 2023-2023, Humana …" Onsite discussion confirmed this was a typographical error. • Page 10 of the 2023 Network Development Plan includes the heading, "Single Case Agreements (Member Specific Letter of Agreements)" that contains incomplete information.	*Recommendation: Revise page 5 of the 2023 Network Development Plan to include the correct timeframe in the first paragraph under "Prior Year Network Analysis." Add the missing information regarding single case agreements to page 10 of the 2023 Network Development Plan.*	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, addresses network gap classifications of low, mid-low, mid-high, and high, but does not define these categories. Post-onsite, Humana submitted a draft revision of Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, which defined the network gap categories.	*Recommendation: Finalize revisions to Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, which define the network gap categories.*			✓
The contractually required statement that some providers may choose not to perform certain services based on religious or moral beliefs could not be located on the online "find a doctor" tool.	*Quality Improvement Plan: Revise the online 'find a doctor" tool to include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. Refer to the SCDHHS Contract, Section 3.12.5.7.*			✓
Policy SC.QLT.006, Continuity and Coordination of Care, does not provide information about how the health plan monitors continuity of care across the health care delivery system.	*Recommendation: Revise Policy SC.QLT.006, Continuity and Coordination of Care, to include Humana's processes for monitoring continuity of care between providers.*	✓		
Member Services				
Discrepancies were noted in the timeframe for grievance acknowledgement, as follows: • Policy SC.MCC.005, Member Grievances and Appeals, states the grievance acknowledgement timeframe is 10 calendar days. • Policy and Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, does not define the timeframe for grievance acknowledgement. • The Member Handbook and Provider Manual state the grievance acknowledgement timeframe is indicate that members are informed a letter will be sent within five business days from the date of receipt of a grievance.	*Quality Improvement Plan: Revise the documents listed above to consistently document the timeframe for grievance acknowledgement. Include the acknowledgement timeframe in Policy SC.GAA.001.,*		✓	
Grievance acknowledgement letters do not indicate that a grievance may be filed if the member disagrees with an extension as referenced in the *SCDHHS Contract, Section 9.1.6.1.4* and *9.1.6.1.5*.	*Quality Improvement Plan: Revise Grievance acknowledgement letters to indicate that a grievance may be filed if the member disagrees with an extension as referenced in the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*	✓		
Three grievance files were closed with significant time remaining, with instructions for the member to contact	*Quality Improvement Plan: Establish processes or training to ensure that grievances are not closed with significant time remaining when additional information is needed.*		✓	

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
the health plan to provide further information.				
Quality Management				
Humana's website did not include any Humana specific performance measures.	*Recommendation: Include results of select HEDIS measures and CAHPS results on Humana's website.*	✓		
The following errors were identified in the 2022 and 2023 QI work plans: • The Nurse Advice Line activity (line 14 of the 2022 work plan) indicated a report for this activity would be submitted to the Quality Assurance Committee. There was no documentation in the committee minutes that this report was provided. • The Quality Assurance Committee was incorrectly referred to as the Quality Assessment Committee and the Quality Assessment and Performance Improvement Committee in the 2022 and 2023 work plans. • In the 2023 work plan, the goal for the NICU activity states, "Track and trend average length of stay." However, the average length of stay is not being reported. The number of NICU admissions and the follow-up provided by Case Management was being reported. The Performance Improvement Projects, line 26 of the 2023 work plan is missing the HPV project.	*Quality Improvement Project: Correct the errors noted in the QI work plans.*	✓		
The lack of a variety of participating network providers on the Quality Assurance Committee as required by the *SCDHHS Contract, Section 15.3.1.2* continues to be an issue for Humana.	*Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.*	✓		
The QAC meeting minutes did not reflect the appointed representative for voting members absent during the meetings. No documentation was included to document when minutes were changed or amended	*Quality Improvement Plan: Document in the QAC meeting minutes who has been appointed as the representative for voting members absent during the meetings. Develop a process for how errors or changes in the committee minutes should be documented and reported to the committee.*	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation was missing data or results and contained goals that were incorrect. <u>These were issues identified during the previous EQR and not corrected.</u>	*Quality Improvement Plan: Correct the errors noted in the 2022 QI Program Evaluation and include a summary of the Delegation Oversight activities.*	✓		
Utilization Management				
The adverse benefit determination letters in Humana's sample denial files and the adverse benefit determination letter templates incorrectly informs members that a written appeal is required when an oral request is submitted.	*Quality Improvement Plan: Remove the requirement that a written appeal request must be submitted following an oral request for an appeal in the adverse benefit determination notices.*			✓
Policy SC.CLI.002, Continuity of Care and Care Transitions, does not address continuity of care while a member is in the appeals process.	*Recommendation: Revise Policy SC.CLI.002, Continuity of Care and Care Transitions, to address continuity of care for members in the appeals process.*	✓		
Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not indicate that members may file a grievance when they disagree with an extension of the grievance resolution timeframe.	*Quality Improvement Plan: Correct policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template to indicate that a grievance can be filed if the filer disagrees with an extension of the grievance resolution timeframe, as required by the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*	✓		
Delegation				
Policy SC.DCO.001 does not include the requirement to notify SCDHHS of any further delegation by a subcontractor (*SCDHHS Contract, Section 2.5.11*).	*Quality Improvement Plan: Include the SCDHHS requirement to notify SCDHHS of any further delegation by a subcontractor in Policy SC.DCO.001. Also ensure this requirement is included in each delegate's contract.*	✓		
Humana provided copies of the annual delegation oversight monitoring. The following issues were identified in the audit tools: • The element regarding the CLIA was marked as not applicable for six of the delegates during the file review. • For three of the delegates, the nurse practitioner agreement was not checked during the file review. This element was marked as not applicable. • Hospital admitting privileges were not checked during the file review for one delegate.	*Quality Improvement Plan: Re-educate staff conducting the annual oversight audits regarding the credentialing and recredentialing requirements that should be checked during the file review.*	✓		

Weakness	Recommendation or Quality Improvement Plan	Quality	Timeliness	Access to Care
Mental Health Parity				
Provider Network is not robust in certain regions; this is reflected in low scores for getting mental health services quickly on the ECHO survey.	*Recommendation: Continue to convene the Network Adequacy Workgroup. Continue the policy of not denying care based on the provider's contracted status.*			✓
Integration issues between FOCUS, the BH vendor who performs reviews when Humana Associates are unable to approve a request, could result in timeliness or access to care issues.	*Recommendation: Continue with training and staff support as well as Joint Operational Committee meetings.*			✓

METHODOLOGY

The process Constellation Quality Health used for the EQR activities was based on protocols CMS developed for the EQR of a Medicaid MCO/PIHP and focuses on the four federally mandated EQR activities of compliance determination, validation of performance measures, validation of performance improvement projects, and validation of network adequacy.

On December 4, 2023, Constellation Quality Health 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 and reviewed in Constellation Quality Health'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 February 7th and 8th. 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 in each section.

A. Administration

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

The review of the Administration section encompasses policy development and management, staffing, information systems, compliance/program integrity, and confidentiality.

Humana develops and implements policies to provide guidance for day-to-day health plan operations. New policies are reviewed by applicable policy owners, Directors, Vice Presidents, Medical Directors, and some committees, with final review and approval by the Regulatory Compliance Department. Humana houses policies for staff access in its policy management platform and on a SharePoint site. All policies are reviewed at least annually, and staff are educated about new and revised policies by departmental leadership. It was noted that Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, includes multiple references to the term "policy owner" and one reference to "business owner." Onsite discussion confirmed these terms are synonymous. The current EQR confirmed Humana appropriately addressed the Quality Improvement Plan from the previous EQR. See *Table 6: 2023 Approach to Policies and Procedures QIP Items* for the previously identified issues and Humana's response.

Table 6: 2023 Approach to Policies and Procedures QIP Items

Standard	2023 EQR Findings	2024 EQR Findings
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.	The 2023 EQR and corresponding onsite discussion confirmed Humana implemented a policy review cycle and consolidated and updated many policies. The health plan's process includes review of policies and procedures by the policy's Business Owner and Regulatory Compliance staff to ensure an annual review cycle. Despite these changes, CCME noted continued issues with health plan policies, including: • Humana provided several versions of its Policy Index. The first index listed approximately 156 policies and the second listed approximately 175 policies. During the onsite visit, some policies were referenced or discussed that were not listed on the Policy Index. The final policy index submitted included policies that did not specify a policy number and/or business owner. • Some policies were provided in a draft format. • Some policies did not provide a policy number within the document, although the document file name listed a number. *Quality Improvement Plan: Revise the Policy Index to include all policies followed for conducting health plan activities and functions within SC and to provide a policy number and business owner for each policy listed. Consider adding the most recent*	The issues identified during the previous EQR were corrected. All policies are now written using a standard policy template that includes policy name and number. The Policy Index lists all SC policies and identifies each policy's name, number, policy owner, and review date.

Standard	2023 EQR Findings	2024 EQR Findings
	policy review date for each policy listed in the Policy Index. Ensure all policies include an identifying policy number within the policy. Ensure policies are not left in a draft format once the routine review cycle is complete and the policy is approved.	
Humana's Response: Humana Policy Index is extracted from our Enterprise GRC Tracking system, ESP, to ensure all active policies are listed. Humana has added additional columns to the index to include the business owner and the current review date for each policy. Policies that were in draft format have been approved and published. Policies have also been updated to include the policy number within the document.		

The Organizational Chart displays operational relationships for key areas and is color-coded to indicate key personnel, staff for the South Carolina market, shared services, etc. Overall health plan staffing is sufficient to ensure all required activities and services are provided. The current review confirmed issues related to the Administrator/Chief Executive Officer and Provider Services Manager positions were corrected; however, the Member Services Manager position has been filled on an interim basis for approximately 10 months by an Associate Vice President, Inbound Contacts in MN. This is the second consecutive year Humana has not met the requirements for the Member Services Manager position noted in the *SCDHHS Contract, Section 2*. See *Table 7: 2023 Organizational Chart / Staffing QIP Items* for specific information about the previous review findings, Humana's response, and the current findings.

Table 7: 2023 Organizational Chart / Staffing QIP Items

Standard	2023 EQR Findings	2024 EQR Findings
I B. Organizational Chart / Staffing		
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: 1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));*	The *SCDHHS Contract, Section 2* requires that the "Contractor have a full-time administrator with clear authority over general administration and implementation of requirements set forth in the contract, including responsibility to oversee the budget and accounting systems implemented by the CONTRACTOR, and have the authority to direct and prioritize work, regardless of where performed." Due to discrepancies in the information provided by health plan documentation, reported during the onsite visit, and provided to SCDHHS, it is unclear who fulfills the requirements of the *SCDHHS Contract, Section 2* for the key position of Administrator (CEO, COO, Executive Director, etc.). • The Organizational Chart lists Natalia Aresu as the South Carolina CEO Market Leader.	This issue was corrected. Humana's documentation clearly identifies the Chief Executive Officer.

Standard	2023 EQR Findings	2024 EQR Findings
	• Humana reported to SCDHHS that Ms. Aresu is the Chief Executive Officer. • The "Staffing List 3.23" lists Ms. Aresu as "VP, Medicaid Regional President." • Humana's Organizational Chart lists Kim McElroy as Humana's Director, Market Leadership, and it was confirmed that she is located in South Carolina. However, Ms. McElroy was reported to be the Chief Operating Officer during the onsite visit. • Ms. McElroy was not included in the Key Personnel list reported to SCDHHS. *Quality Improvement Plan: Clearly identify the individual who fulfills the role required by the SCDHHS Contract, Section 2 for a health plan Administrator (CEO, COO, Executive Director, etc.) located within the state of South Carolina.*	
Humana's Response: Kimberly McElroy is the COO for Humana Healthy Horizons of South Carolina. Humana's Organizational Chart has been updated. 6/9/2023: Kimberly McElroy is the COO as indicated on page 1 of the Organizational Chart. Ron Weeden is the interim VP, Medicaid Regional President due to Natalia Aresu transitioning to a new role within the company. Humana notified the SCDHHS of this update on 3/16/2023.		
1.7 *Provider Services Manager;	The *SCDHHS Contract, Section 2* requires a "Provider Service Manager to coordinate communications between the CONTRACTOR and its Subcontracted Providers. There shall be sufficient Provider services staff to enable Providers to receive prompt resolution to their problems or inquiries and appropriate education about participation in the Managed Care Program and maintain a sufficient Provider network." The *SCDHHS Contract* requires the Provider Services Manager to be located within SC. Because of discrepancies in the information provided by health plan documentation, reported during the onsite visit, and provided to SCDHHS, it is unclear who fulfills the requirements of the *SCDHHS Contract, Section 2* for the key position of Provider Services Manager. • Humana reported to SCDHHS that Cynthia Forcade is the Provider Services Manager. • The Key Personnel List provided by Humana indicates Gina Ruiz is the Provider Services Manager. • Per onsite discussion and the "Staffing List 3.23" document provided after the onsite visit, Cynthia Forcade is the Director of Contracting and Gina Ruiz is the Provider Contracting Executive. • There is no Provider Services Manager listed on the "Staffing List 3.23" document.	This issue was corrected. Humana's documentation clearly identifies the Provider Services Manager.

Standard	2023 EQR Findings	2024 EQR Findings
	Quality Improvement Plan: Clearly identify the individual who fulfills the role required by the SCDHHS Contract, Section 2 for a Provider Services Manager located within the state of SC.	
Humana's Response: Gina Ruiz is the Provider Services Manager for Humana Healthy Horizons of South Carolina. Humana's Organizational Chart has been updated.		
1.8 *Member Services Manager;	The *SCDHHS Contract, Section 2* requires a "Member Services Manager who shall coordinate communications with members; serve in the role of member advocate; coordinate issues with appropriate areas within the organization; resolve member inquiries/problems and meet standards for resolution, telephone abandonment rates and telephone hold times; and assist members when necessary to access culturally competent, high quality integrated medical and Behavioral Health care." Taffney Hooks is listed as Humana's Member Services Manager on the SC Medicaid Key Personnel List submitted prior to the onsite visit. However, the Administration tab of the "Staffing List 3.23" document provided after the onsite indicates Ms. Hooks' role as Compliance Lead, and the Member Services tab does not specify anyone in the role of Member Services Manager. The *SCDHHS Contract, Section 2,* requires 1 Full Time Employee (FTE) for both the Member Services Manager position and the Contract Account Manager position. Ms. Hooks is serving in both roles. *Quality Improvement Plan: Hire a full time Member Services Manager located in SC.*	This issue was not corrected. The *SCDHHS Contract, Section 2*, requires that the health plan have one in-state full-time employee to serve as Member Services Manager. This role is currently filled on an interim basis by Brad Utter, Associate Vice President, Inbound Contacts. He is located in MN, and per Humana staff, has been serving as Interim Member Services Manager for approximately 10 months. This is the second consecutive year Humana has not met the contractual requirement for the Member Services Manager position. During onsite discussion, Humana reported that the position is expected to be filled on a permanent basis by 2/25/24.
Humana's Response: Tawana Barksdale is the Member Services Manager for Humana Healthy Horizons of South Carolina. Humana's Organizational Chart has been updated. 6/9/2023: Humana is in the process of creating a requisition for the role of SC Member Services Manager per the SC MCO contract requirement. Brad Utter is interim until the role is filled. He's listed on page 3 of the org chart.		
2. Operational relationships of MCO staff are clearly delineated.	Humana's Organizational Chart does not display the operational relationships for key areas such as Member Services, Provider Services, Grievances and Appeals, Network Management, etc. Operational relationships of staff are also not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists.	This issue was corrected. The Organizational Chart displays operational relationships for key areas and is color-coded to indicate key personnel, staffing for the South Carolina market, shared

Standard	2023 EQR Findings	2024 EQR Findings
	Quality Improvement Plan: Revise the Organizational Chart to denote all key staff and their location. Revise the Organizational Chart to display the reporting structure for all staff/departments. Staffing Lists and Key Personnel Lists should be consistent with the Organizational Chart and include staff credentials and location.	services, etc. Vacant positions are noted.
Humana's Response: Humana's Organizational Chart has been updated to reflect reporting structures for all departments and includes staff credentials and location. 6/9/2023: Humana's Organizational chart has been updated to show that once hired, the Member Services Manager role will report directly to the market.		

The Corporate Compliance Plan, the Special Investigations Unit Anti-Fraud Plan, and related policies and procedures describe processes to comply with contractual, state, and federal requirements and to monitor, detect, prevent, and investigate fraud, waste, and abuse (FWA). The code of conduct, titled Ethics Every Day, is a resource guide that addresses expectations for employee conduct and provides information about reporting compliance violations. Compliance training is provided to employees, the Board of Directors, and contractors within 30 days of hire, election, or contract date, and annually thereafter. Employees must read and agree to comply with Ethics Every Day within 30 days of hire and annually. Changes to statutory and regulatory requirements, company policies and procedures, and standards of conduct are communicated regularly in a variety of ways, including workplace posters, Humana's intranet site, the Enterprise Risk & Compliance SharePoint site, and the internal social networking site.

Roles and responsibilities of Corporate Compliance Officers and Compliance Committees are addressed in the Corporate Compliance Plan. The draft Humana Healthy Horizons in South Carolina Compliance Plan, provided after the onsite, includes the role of the health plan's Compliance Officer. The Corporate Compliance Committee, chaired by the corporate Chief Compliance Officer, is the decision-making authority for all compliance matters. Market Compliance Officers are members of this committee. Issues that may affect SC are identified and discussed during Medicaid Compliance Steering Committee meetings. Membership of the Medicaid Compliance Steering Committee includes business and compliance leaders throughout Humana that support the SC Medicaid program, including the South Carolina Medicaid Compliance Officer. Humana staff reported that a SC Compliance Committee is being established, will be chaired by the SC Compliance Officer, and will begin meeting by the end of Q1 2024.

Humana enforces a strict no-retaliation policy for those who report suspected noncompliance or FWA issues. Reporting avenues allow for confidential and anonymous reporting, and include email, telephonic, and/or internet-based reporting options to contact the Corporate Compliance Officer, Ethics Help Line and the Ethics Office, Privacy Office, Enterprise Information Protection, Security

Incident Response Team, Internal Audit Consulting Group, Special Investigations Unit, and the Associate Support Center. Humana conducts timely investigations of identified compliance and FWA issues, and promptly corrects problems to reduce risk for recurrence and ensure ongoing compliance. Humana also conducts internal monitoring and auditing activities to evaluate compliance with state and federal requirements and the overall effectiveness of the compliance program. Humana voluntarily self-reports any identified compliance and FWA issues to appropriate regulatory bodies.

Humana contracts with a vendor to conduct exclusion and sanction screenings of employees, the Board of Directors, delegated entities, network providers, etc. These screenings are conducted before hire or contract execution and then monthly. Policy SC.ETC.001, Ineligible Persons Entities Screening Requirements, Policy SC.DCO.001, Delegation Policy, etc., define the specific screenings conducted. These documents also specify the actions taken when a positive match is determined. Constellation Quality Health noted that the 2023 Subcontractor Monitoring and Oversight Plan addresses queries of the System for Award Management but does not address other sanctions checks required by the *SCDHHS Contract, Section 11.2.10*.

Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, describes the program used to manage members with a history of inappropriate use of specific medications. This policy appropriately addresses the timeframe within which members may request a different pharmacy or request an appeal of the decision to include the member into the program. However, the policy does not clearly address the process followed when a member appeals the decision to restrict them into the program. The policy also omits the 72-hour limitation for an emergency supply of medication and does not address the process for notifying members when the lock-in restriction is removed.

Humana educates employees, providers, and subcontractors about the expectation that they maintain the confidentiality of protected information. Staff must sign a Confidentiality Agreement during Ethics and Compliance Training.

Information Management Systems Assessment

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

Humana receives encounter files from various sources, including delegated partners, clinical registries, and the State, and uses the file data to populate member demographics and other attributes. All payment programs are internally measured for quality and performance. Humana's documentation indicates claims processing goals meet or exceed contractual requirements for claim completion.

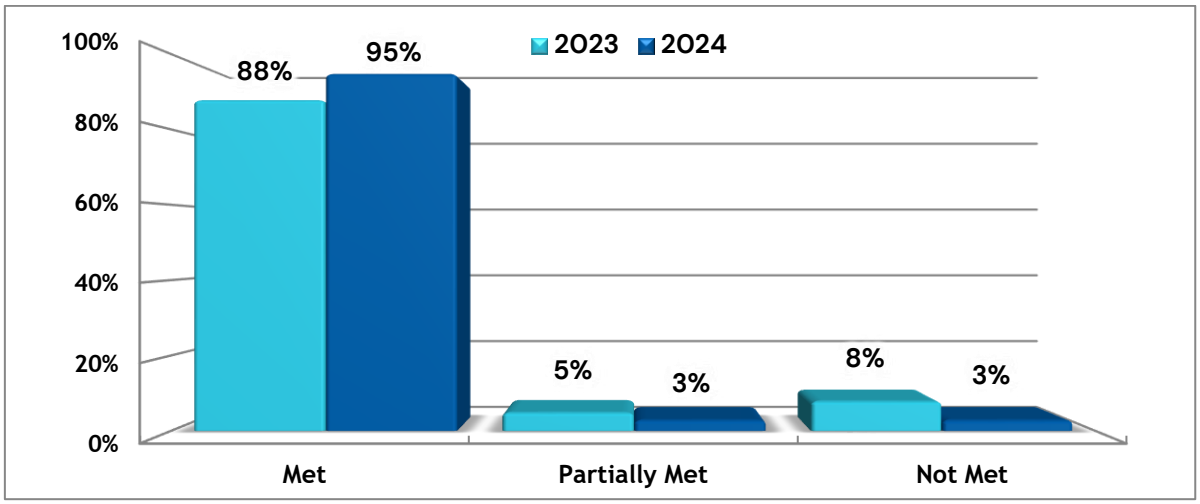
Humana's Health Information Trust Alliance audit process incorporates requirements for Federal Information Processing Standards Publication and several other compliance standards, including

the Health Insurance Portability and Accountability Act (HIPAA). System and data backups meet the security requirements for both HIPAA and the Sarbanes-Oxley Act. Data is categorized as Confidential, Restricted, Internal, and Public. Customer data, such as personal identifiable information, protected health information, and non-public financial information, is treated as Confidential. Data is secured via regulatory compliant protection or encryption standards, and there are layers of logical security to ensure access to sensitive data is highly restricted and audited. Access for all users is managed through Role-Based Access Control (RBAC).

Information Systems Capability Assessment documentation states data protection solutions align with the IT Disaster Recovery Program Standard, which provides details on requirements for production data hosted in the data center and in the public cloud and addresses data restoration procedures, retention, archiving, and disaster recovery. Mission critical Tier 1 applications are replicated to the alternate disaster recovery site to support data loss of less than five minutes.

As noted in *Figure 2: Administration Findings*, 95% of the Administration standards were scored as "Met." One standard (3%) was scored as "Partially Met" and one (3%) was scored as "Not Met."

Figure 2: Administration Findings



Percentages may not total 100% due to rounding.

Table 8: Administration Comparative Data

Section	Standard	2023 Review	2024 Review
General Approach to Policies and Procedures	The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Not Met	Met

Section	Standard	2023 Review	2024 Review
Organizational Chart / Staffing	The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles: *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED))	Not Met	Met
	*Contract Manager	Not Met	Met
	*Provider Services Manager	Not Met	Met
	Operational relationships of MCO staff are clearly delineated	Partially Met	Met
Compliance/ Program Integrity	The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP)	Met	Partially Met

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

Table 9: Administration Strengths

Strengths	Quality	Timeliness	Access to Care
Humana revised policies and procedures to use a standard policy template that specifies a policy name and number.	✓		
The Organizational Chart displays operational relationships for key areas and indicates key personnel, staff for the South Carolina market, shared services, and vacant positions.	✓		
Humana has a focus on implementing and maintaining security measures that adhere to data security standards.	✓		
Humana has a robust infrastructure to replicate data and prevent data loss should an outage or incident occur.	✓		
Information systems documentation is regularly reviewed and updated as indicated by timestamps and change logs.	✓		
Humana's Corporate Compliance Plan and Special Investigations Unit Anti-Fraud Plan address the Compliance Program and activities to prevent, detect, and respond to FWA. Related policies and procedures provide additional information about compliance and FWA detection and prevention activities.	✓		
The code of conduct, Ethics Every Day, is comprehensive and addresses expectations for ethical business conduct and practices.	✓		
Humana investigates alleged or suspected noncompliance and illegal/improper activities and takes immediate action to address confirmed violations.	✓		

Strengths	Quality	Timeliness	Access to Care
Policies, the Corporate Compliance Plan, and Ethics Every Day address confidentiality of member information and other protected information.	✓		

Table 10: Administration Weaknesses, Recommendations, and Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, includes multiple references to the term "policy owner;" however, it includes one reference to "business owner." Onsite discussion confirmed these terms are synonymous.	*Recommendation: Revise Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, to use either "policy owner" or "business owner."*	✓		
The 2023 Subcontractor Monitoring and Oversight Plan states, "Prior to contract execution and regularly thereafter, each Subcontractor and its owners, directors, and managing employees are checked against the SAM.gov OIG exclusion database to ensure that it is not debarred or otherwise prohibited from supporting federal or state contracts." The 2023 Subcontractor Monitoring and Oversight Plan does not address requirements for checking the SSDMF, LEIE, the SC List of Excluded Providers, or the SC List of Providers Terminated for Cause.	*Recommendation: Revise the 2023 Subcontractor Monitoring and Oversight Plan to include all required queries for each subcontractor. Refer to the SCDHHS Contract, Section 11.2.10.*			✓
Issues noted with Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, include: • Regarding appeals of the lock-in determination, page two of the policy states, "If the member files an appeal, they will be granted a stay of action and removed from the lock in program." Onsite discussion of this finding revealed that the member is only removed from the program until the appeal determination is made. • The policy does not include the 72-hour limitation on an emergency supply of	*Quality Improvement Plan: Revise Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, to include:* • *Full information about the process followed when members appeal inclusion in the lock-in program.* • *The limitation of 72 hours for emergency supply of medication.* • *The process for notifying members when they are removed from the lock-in program.*			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
medication included in an override. Refer to the *SCDHHS Contract, Section 11.10.3.5*. • The policy does not address the process for notifying members when the lock-in restriction is removed, as required by the *SCDHHS Contract, Section 11.10.5*.				

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					Processes for policy management are found in Policy SC.MAPR.001, Maintenance of Written Policies and Procedures. New policies are reviewed by applicable policy owners, Directors, Vice Presidents, and Medical Directors before review by relevant committees. Final policy approval is granted by the Regulatory Compliance Department. Approved policies are stored in the Policy Program Management (PPM) application and in the Medicaid Audit Policy and Reporting SharePoint site for employee access. All policies are reviewed at least annually, and staff are educated about new and revised policies by departmental leadership. It was noted that Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, includes multiple references to the term "policy owner;" however, it includes one reference to "business owner." Onsite discussion confirmed these terms are synonymous.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise Policy SC.MAPR.001, Maintenance of Written Policies and Procedures, to use either "policy owner" or "business owner."
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));	X					Dietrick Williams is Humana's CEO.
1.2 Chief Financial Officer (CFO);	X					Craig Stokan is the Chief Financial Officer.
1.3 * Contract Manager;	X					Humana's Contract Manager is Taffney Hooks.
1.4 Information Systems Personnel;						
1.4.1 Claims and Encounter Manager/ Administrator,	X					
1.4.2 Network Management Claims and Encounter Processing Staff,	X					
1.5 Utilization Management (Coordinator, Manager, Director);	X					Nadelyn Morales is the Utilization Management Director. She is a Registered Nurse, licensed in FL under a Multistate License to practice in all Nurse Licensure Compact states.
1.5.1 Pharmacy Director,	X					Melissa Perraut is the Pharmacy Director. She is a Registered Pharmacist located and licensed in KY.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Ashley Franciscus is the Quality Improvement Director, located in SC.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;	X					Gina Ruiz is the Provider Services Manager.
1.7.1 Provider Services Staff,	X					
1.8 *Member Services Manager;			X			The *SCDHHS Contract, Section 2*, requires that the health plan have one in-state full-time employee to serve as Member Services Manager. This role is currently filled on an interim basis by Brad Utter, Associate Vice President, Inbound Contacts. He is located in MN, and per Humana staff, has been serving as Interim Member Services Manager for approximately 10 months. This is the second consecutive year Humana has not met the contractual requirement for the Member Services Manager position. During onsite discussion, Humana reported that the position is expected to be filled on a permanent basis by 2/25/24.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Hire a full time Member Services Manager located in SC.
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Ayo Gathing is the Medical Director. She has overall responsibilities for Utilization Management and Quality functions. Dr. Robert Thompson is the Medical Director, Clinical. His primary functions include medical necessity reviews and UM processes.
1.10 *Compliance Officer;	X					Regina Moore is the Compliance Officer.
1.10.1 *Program Integrity Coordinator;	X					Troy Jefferson is the Program Integrity Coordinator
1.10.2 Compliance/ Program Integrity Staff;	X					
1.10.3*Program Integrity FWA Investigative/Review Staff;	X					Humana reported a membership of 27,478 and three Fraud and Waste Investigators located in SC. The three investigators' credentials include Certified Fraud Examiner, Accredited Health Care Fraud Investigator, and/or law enforcement background.
1.11 * Interagency Liaison;	X					Tawana Barksdale is the Interagency Liaison.
1.12 Legal Staff;	X					Beatriz Jaramillo is Legal Counsel.
1.13 *Behavioral Health Director.	X					Lindsay Johnson, LMSW is the Behavioral Health Director.
2. Operational relationships of MCO staff are clearly delineated.	X					The Organizational Chart displays operational relationships for key areas and is color-coded to indicate key personnel, staff for the South Carolina

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						market, shared services, etc. Vacant positions are noted.
I C. Information Management Systems *42 CFR § 438.242, 42 CFR § 457.1233 (d)*						
1. The MCO processes provider claims in an accurate and timely fashion.	X					Claims processing goals for Humana meet or exceed the *SCDHHS Contract* requirements. The MCO's documentation states the benchmark is 90% of all clean claims completed within 30 days of receipt and 99% of clean claims completed within 90 days of receipt.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Humana's Health Information Trust Alliance (HITRUST) audit process incorporates the requirements for Federal Information Processing Standards Publication (FIPS 140-2) and several other compliance standards, including those of the Health Insurance Portability and Accountability Act (HIPAA). Additionally, Humana's system and data backups meet the security requirements for both HIPAA and the Sarbanes-Oxley Act (SOX).
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Humana receives encounter files from delegated partners, clinical registries, and states. Data from these files are used to populate member demographics and other attributes like aid categories.
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					All of Humana's payment programs are internally measured for quality and performance. The payment programs incorporate quality measures that must be met for the provider to receive any financial rewards for improving

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						performance. Each of the quality measures is reported quarterly, with drill downs made available to identify patient and surgeon level detail.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Humana has a defined data classification and data handling policy that categorizes data into categories – Confidential, Restricted, Internal, and Public. Customer data, such as personal identifiable information, protected health information, and any non-public financial information, is treated as confidential. Data security at rest and in motion is always secured via regulatory compliant protection or encryption standards. Humana has also implemented numerous layers of logical security to ensure access to sensitive data is highly restricted and audited.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Access for all users is managed through Role-Based Access Control (RBAC). Users must request access based on their business role. All Humana associates have access to the minimum necessary information necessary to perform their job responsibilities. Humana's physical access control system is a centralized, network-based system with compartmented access privileges specific to the data centers. Facility access is segmented into specific areas. Access privileges to each of area requires director oversight and approval.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. The MCO has a disaster recovery and/or business continuity plan that has been tested, and the testing has been documented.	X					Humana's Information Systems Capability Assessment (ISCA) documentation states data protection solutions align with the IT Disaster Recovery (ITDR) Program Standard. The standard provides detail on requirements for production data hosted in the data center and in the public cloud. It also addresses data restoration procedures, retention, archiving, and disaster recovery. Additionally, mission critical Tier 1 applications are replicated to the alternate disaster recovery site to support a data loss less than five minutes.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					The Corporate Compliance Plan defines the goals and scope of the Compliance Program and addresses processes and expectations for compliance with applicable laws, regulations, and requirements and for appropriate business behavior. The Special Investigations Unit Anti-Fraud Plan addresses procedures for preventing and detecting fraud, waste, and abuse (FWA).
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						The Corporate Compliance Plan refers to "Ethics Every Day," a resource guide for employees that addresses expectations for conduct and provides information

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						about reporting compliance violations. Employees must read and agree to comply with Ethics Every Day within 30 days of employment and annually. Humana provided a copy of Ethics Every Day. It addresses conflicts of interest, gifts, favors, travel, entertainment, marketing practices, protection of information, doing business with US and foreign governments, FWA, workplace conduct, and employment practices. It also includes definitions of related terminology and contact information for various resources, such as compliance officers and department, the ethics office, etc.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						Roles and responsibilities of Corporate Compliance Officers are addressed in the Corporate Compliance Plan. After the onsite, Humana provided a copy of the draft Humana Healthy Horizons in South Carolina Compliance Plan, which states the local Compliance Officer "implements the South Carolina compliance plan and oversees fraud, waste, and abuse (FWA) activities while also serving as the liaison with the South Carolina local program integrity team."
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						Humana provided organizational charts for its Compliance and Information Technology Departments.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.4 Information about the Compliance Committee;						Roles and responsibilities of various Corporate Compliance Committees are addressed in the Corporate Compliance Plan.
2.5 Compliance training and education;						The Corporate Compliance Plan and the Compliance Plan Matrix provide an overview of compliance training, which is provided to employees, the Board of Directors, and contractors within 30 days of hire, election, or contract date. In addition, annual Ethics & Compliance Training is required for all employees, providers, and subcontractors. New employees must read and agree to comply with Ethics Every Day within 30 days of hire and annually. The Ethics & Compliance training addresses multiple topics, such as privacy, ethics, antitrust, compliance, steps Humana takes to help prevent FWA, and reporting of FWA. The FWA module includes the False Claims Act, Antikickback, Whistleblower Protection, examples of FWA, and potential fraud indicators. Additional, role-specific, and specialized compliance training is provided as needed for various job functions. Humana reviews training content annually and updates the content as needed to

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						reflect current processes and material changes in regulations, laws, or policies. Providers and subcontractors are required to comply with Humana's Ethics Every Day for Contracted Health Care Providers and Third Parties and the Compliance Policy for Contracted Health Care Providers and Third Parties. These documents address reporting methods and standards related to reporting suspected or actual noncompliance or FWA. Certification of completion and compliance with these requirements is required at the time of new hire/contract orientation and annually. These documents are available through Availity, Humana's secure provider portal, or online through Humana's DocuShare site. Humana sends new network providers a welcome letter outlining education and training requirements. The letter includes links to online resources, such as Ethics Every Day, the Compliance Policy, etc.
2.6 Lines of communication;						Per the Corporate Compliance Plan, Humana regularly communicates changes to statutory and regulatory requirements, company policies and procedures, and standards of conduct to employees via: • Physical media, such as workplace posters • Humana's intranet site

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The Enterprise Risk & Compliance SharePoint site • Humana's internal social networking site (Buzz) The Corporate Compliance Plan states Humana enforces a strict no-retaliation policy for those who report suspected noncompliance or FWA issues. Reporting resources allow for confidential and anonymous reporting, and include: • Direct email to the Corporate Compliance Officer • Telephonic and internet-based reporting to the Ethics Help Line and the Ethics Help Line Web • Email to the Ethics Office, Privacy Office, Enterprise Information Protection, Security Incident Response Team, and Internal Audit Consulting Group • Email or telephonic reporting to the Special Investigations Unit • Online to the Associate Support Center at go/ASC • The Agent Investigation Unit for agent complaints
2.7 Enforcement and accessibility;						Expectations for ethical conduct and disciplinary standards are available to staff on the company's intranet sites. Disciplinary standards apply to all staff. Company leadership and staff from Human Resources, the Ethics Office, and the Ethics help line are available if staff

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						have questions about compliance expectations and/or disciplinary policies.
2.8 Internal monitoring and auditing;						The Corporate Compliance Plan and Compliance Plan Matrix provide an overview of internal monitoring and auditing activities to evaluate compliance with state and federal requirements and the overall effectiveness of the compliance program. Activities include: • Monthly monitoring of critical state contract requirements, with performance results published to compliance and executive leadership through dashboards, scorecards, etc. • Annual compliance risk assessments using findings from ongoing monitoring activities and Risk Assessment Subcommittees. • Development of an annual work plan to outline the monitoring/auditing activities for the year. The work plan is updated throughout the year and reviewed quarterly by the Chief Compliance Officer.
2.9 Response to offenses and corrective action;						Humana responds to issues as they are raised, conducts timely investigations of identified compliance and FWA issues, and promptly corrects problems to reduce risk for recurrence and ensuring ongoing compliance. Humana voluntarily self-reports identified issues of noncompliance or FWA to appropriate regulatory bodies for the line of business.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.10 Data mining, analysis, and reporting;						As noted in the Special Investigations Unit Anti-Fraud Plan, data mining activities are based on identified risks using software to detect FWA by conducting analyses of outliers, trends, anomalies, statistics, and other rules-based anomaly detection. The Compliance Plan Matrix states the Fraud Research, Analytics, and Concepts Team (FRAC) conducts data mining based on identified risks. Data mining includes comparing claims information against other data, such as provider information, diagnoses, drugs purchased, member information, etc., to aid in identifying potential FWA.
2.11 Exclusion status monitoring.						Policy SC.ETC.001, Ineligible Persons Entities Screening Requirements, and the South Carolina Medicaid Addendum indicate a vendor conducts screenings of employees, the Board of Directors, delegated entities, network providers, etc. before hire or contract execution and then monthly to determine any exclusions from participation in federal programs. The screenings include the System for Award Management (SAM), Office of Inspector General List of Excluded Individuals and Entities (LEIE), Medicaid state exclusion lists (SC List of Excluded Providers and the SC List of Providers Terminated for Cause), the Social Security Administration's Death

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Master File (SSDMF). The National Practitioner Data Bank (NPDB) is also checked for individual practitioners at initial credentialing and recredentialing. When a match is determined, Humana notifies SCDHHS' Division of Program Integrity promptly and takes any necessary actions. Immediately upon discovery, Humana reports to SCDHHS any network providers or subcontractors that have been debarred, suspended, and/or excluded from participation in Medicaid, Medicare, or any other program. Policy SC.DCO.001, Delegation Policy, addresses exclusion monitoring requirements for potential vendors/contractors. The 2023 Subcontractor Monitoring and Oversight Plan states, "Prior to contract execution and regularly thereafter, each Subcontractor and its owners, directors, and managing employees are checked against the SAM.gov OIG exclusion database to ensure that it is not debarred or otherwise prohibited from supporting federal or state contracts." The 2023 Subcontractor Monitoring and Oversight Plan does not address requirements for checking the SSDMF, LEIE, the SC List of

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Excluded Providers, or the SC List of Providers Terminated for Cause. *Recommendation: Revise the 2023 Subcontractor Monitoring and Oversight Plan to include all required queries for each subcontractor. Refer to the SCDHHS Contract, Section 11.2.10.*
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					Humana's Corporate Compliance Committee is chaired by the corporate Chief Compliance Officer and is the decision-making authority for compliance matters. This committee reports to the CEO and to the Audit Committee of the Board of Directors. Membership includes Humana's CEO and the full executive leadership team, market compliance officers, the Chief Audit Officer, and other senior leaders. The Committee meets quarterly and as needed to monitor significant issues, metrics, training, and adherence to compliance policies. Questions, concerns, and reports of suspected or potential violations are trended and reported to the Corporate Compliance Committee. Issues that may affect SC are identified and discussed during Medicaid Compliance Steering Committee meetings. The Medicaid Compliance Steering Committee membership includes business and compliance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						leaders throughout Humana that support the SC Medicaid program, including the SC Medicaid Compliance Officer. This committee is not a decision-making body. This committee meets monthly and as needed. Primary functions include evaluating overall compliance based on key indicators, monitoring and reporting internal Medicaid compliance risks, and accelerating the closure of external corrective action plans and other notifications of non-compliance. Humana staff reported during the onsite that they are establishing a SC Compliance Committee that will be chaired by the SC Compliance Officer. A charter has been drafted, and the health plan expects to hold the first meeting of the SC Compliance Committee by the end of Q1 2024.
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					The Special Investigations Unit Anti-Fraud Plan, Policy SC.CCM.003, South Carolina Addendum to Special Investigations Unit AntiFraud Plan, and related policies provide detailed information about processes to prevent, detect, and respond to FWA.
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					The Special Investigations Unit Anti-Fraud Plan, found in Policy SC.CCM.002, provides a detailed description of the process for investigating FWA.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The Special Investigations Unit (SIU) is responsible for investigations related to fraud and complex abuse. • The Provider Payment Integrity (PPI) unit conducts reviews and/or audits related to waste and abuse. • The Risk Adjustment Integrity Unit (RAIU) investigates instances of FWA in Humana's provider network that impact the integrity of the risk adjustment submissions.
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					The SIU Antifraud Plan and the South Carolina Addendum to the Special Investigations Unit AntiFraud Plan address prepayment reviews and other activities that may be taken to prevent loss of funds. The South Carolina Addendum to the Special Investigations Unit AntiFraud Plan also addresses provider payment recoupments and recovery of funds when there has been payment on fraudulent or inappropriate claims or codes.
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).		X				Humana manages members with inappropriate use of certain medications through the Pharmacy Lock-in Program, as described in Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program. The Overutilization Review and Monitoring department manages the program, and members are selected for inclusion based on review of SCDHHS-

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						generated quarterly reports, along with the member's pharmacy claims history, by a pharmacist to determine the appropriateness of inclusion. Policy SC.RX.004 appropriately addresses member requests to select a different pharmacy; however, the information included about appealing the lock-in decision is unclear. Page two of the policy states, "If the member files an appeal, they will be granted a stay of action and removed from the lock in program." Onsite discussion of this finding revealed that the member is only removed from the program until the appeal determination is made. If the member's appeal is denied, the member is included in the program and restricted to one pharmacy. Policy SC.RX.004 addresses circumstances under which a mediation override may be granted but does not include the 72-hour limitation on an emergency supply of medication included in an override. Refer to the *SCDHHS Contract, Section 11.10.3.5* Additionally, Policy SC.RX.004 does not address the process for notifying members when the lock-in restriction is

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						removed, as required by the *SCDHHS Contract, Section 11.10.5*. *Quality Improvement Plan: Revise Policy SC.RX.004, South Carolina Medicaid Pharmacy Lock-In Program, to include:* • *Full information about the process followed when members appeal inclusion in the lock-in program.* • *The limitation of 72 hours for emergency supply of medication.* • *The process for notifying members when they are removed from the lock-in program.*
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					Humana expects all employees, providers, and subcontractors to maintain confidentiality of protected information. Staff are required to sign a Confidentiality Agreement during the Ethics and Compliance Training conducted at employment and annually. Violations of confidentiality may result in disciplinary action, up to and including termination, as stated in Policy SC.MKA.005, Confidentiality. The 2023 Ethics & Compliance Training document includes a detailed section titled Protecting Privacy, which addresses:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• The responsibility of all staff for protecting information. • Examples of protected information (personal information, protected health information, sensitive health information, and protected financial information). • State and federal privacy laws. • Information disclosure and sharing. • The Confidentiality Agreement.

B. Provider Services

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

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

Provider Credentialing and Selection

Credentialing processes and requirements are found in the 2023 Healthy Horizons in South Carolina CORE Credentialing & Recredentialing Program Description (Credentialing Program Description) and Policy SC.CDT.001 – Credentialing, Recredentialing, and Ongoing Sanction Monitoring. For credentialing and recredentialing, Category I files meet all established credentialing criteria, are approved daily by the Medical Director, and presented during the next Credentials Committee meeting. Category II files do not meet all credentialing criteria and require review by the Credentials Committee.

The Credentials Committee, which is chaired by a Humana Medical Director and meets monthly, makes the ultimate decisions regarding credentialing and recredentialing. The quorum is defined as the presence of 60% of voting members. Voting membership includes actively practicing network providers with unrestricted SC licensure and no role in Humana's management activities. Current voting members include family medicine, internal medicine, obstetrics and gynecology, and psychiatry physicians as well as a pharmacist and a family medicine nurse practitioner. During the previous EQR, Constellation Quality Health recommended that Humana attempt to recruit additional specialty providers to serve on the Credentials Committee. During the current EQR, Humana reported that recruitment activities continue but have thus far been unsuccessful.

Constellation Quality Health reviewed a sample of initial credentialing and recredentialing files for practitioners and organizational providers. For the initial credentialing files for practitioners, issues were noted with verification of admitting privileges or arrangements, verification of CLIA certification, and failure to collect collaborative agreements between nurse practitioners and their collaborating physician. No issues were noted with the recredentialing practitioner files and the organizational provider initial credentialing and recredentialing files.

As noted in health plan policy, Humana routinely monitors network providers for sanctions and exclusions through the Council for Affordable Quality Healthcare (CAQH) SanctionsTrack module. When a provider is confirmed to have sanctions or exclusions, Humana terminates the provider, adds a sanctions code to the provider's record, and notifies the SCDHHS Division of Program Integrity.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

Humana educates network providers to ensure their compliance with Medicaid policies, procedures, laws, and regulations. New provider orientation is conducted within 30 days of the letter of credentialing or the contract effective date. Ongoing provider education is conducted to update providers about essential information, such as provider requirements, member care expectations, changes in policies and procedures, billing, and issues resolution processes, etc. This ongoing education is provided through Provider Manual updates, newsletters, educational materials, mailings, faxes, bulletins, the website, provider portals, and during in-person, virtual, and/or web-based training sessions. In addition, Humana holds Town Halls in at least four regional locations throughout the state each year.

Issues noted during the previous EQR related to provider education, Humana's response to those items, and the current findings are detailed in *Table 11: Previous Provider Education QIP Items*.

Table 11: Previous Provider Education QIP Items

Standard	2023 EQR Findings	2024 EQR Findings
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.	Policy SC.NNO.007, Provider Orientation and Annual Training, provides an overview of the process for conducting new provider orientation; however, it is not specific to SC. Also, the policy states the Contractor "Conducts orientation covering the appropriate issues outlined on the New Provider Orientation Training and/or Checklist, (Resource A) and any other market specific requirements." Section VIII (Resources) of the policy lists two documents, including Sample New Provider Orientation Checklist Market and South Carolina Medicaid Annual Training Requirements. However, Humana reported that the SC plan does not "utilize a new provider orientation checklist for SC Medicaid new provider orientation. The referenced policy SC.NNO.007 is generic to all markets and all lines of business. We follow the state-specific guidelines for SC Medicaid that are referenced in the policy." The reference in the policy to the New Provider Orientation Checklist was an issue noted during the previous EQR.	This issue was corrected. Policy SC.NNO.007, Provider Orientation and Annual Training was updated to be specific to South Carolina and to clearly document processes for initial provider education for the South Carolina market.

Standard	2023 EQR Findings	2024 EQR Findings
	Quality Improvement Plan: Revise Policy SC.NNO.007, Provider Orientation and Annual Training, to clearly document processes for initial provider education for the South Carolina market.	
Humana's Response: Humana has revised policy SC.NNO.007 –Provider Orientation and Training, removing references to the Provider Orientation Checklist and clearly documenting initial training for providers.		
2. Initial provider education includes: 2.10 Reassignment of a member to another PCP;	CCME did not identify information in the Provider Manual regarding reassignment of a member to a different PCP. This was discussed during the onsite and Humana staff were unable to provide a clear explanation of any circumstances under which a PCP can request reassignment of a member to another PCP. After the onsite, Humana provided the following response: "Humana Healthy Horizons in South Carolina follows the procedures outlined in our Enterprise-Wide Policy #5051331- Procedure- Government Programs PCP Request for Member Transfer. This policy was last reviewed on September 8, 2022. HHH in SC continues to work diligently to streamline our policies and procedures. Humana Healthy Horizons in South Carolina will develop a SC Medicaid specific policy regarding PCP request for member transfer." *Quality Improvement Plan: Develop a South Carolina market policy to define the requirements and process for a PCP to request reassignment of a member to a different PCP. Include information about circumstances under which a provider may request transfer of a member to another PCP in the Provider Manual.*	This issue was corrected. Processes for PCP requests to reassign a member to another PCP are detailed in a new policy, Policy SC.NNO.015, Primary Care Physician (PCP) Request for Member Transfer, and included in the Provider Manual.
Humana's Response: Humana has created an SC-specific policy, SC.NNO.016 –Primary Care Physician (PCP) Request for Member Transfer, to document the process for PCP request for reassignment. This process has also been updated to reflect in the Provider Manual.		

Through the Clinical Practice Guideline Physician Committee (CPGPC) and the Corporate Quality Improvement Committee, Humana adopts clinical practice guidelines (CPGs) and preventive health guidelines (PHGs) that are applicable to Humana's membership. During the previous EQR, Humana reported there were no SC physicians on the CPGPC. Humana currently reports that a SC physician has been added to the committee's membership. Humana disseminates the PHGs and CPGs to providers through the Provider Manual, newsletters, and the website. Providers may

contact Provider Relations Representatives or the Care Management Department to request printed copies.

Humana educates providers about expectations for communicating with other providers to ensure continuity and coordination of care and monitors provider compliance through medical record audits. Policy SC.QLT.006, Continuity and Coordination of Care, states, "Monitoring member's continuity of care allows Humana Healthy Horizons in South Carolina (HHH SC) to optimize medical care across the health care delivery system and improve member outcomes." However, the policy does not provide information about how this monitoring is conducted. The process for conducting annual evaluations of continuity and coordination of care for medical and behavioral health providers was noted in the 2023 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description. Humana staff confirmed this is done annually.

Providers are also educated about medical record documentation standards and record-keeping practices. Humana assesses provider compliance with these standards and practices through medical record audits, as documented in Policy SC.QLT.010, Medical Record Review. The goal score is 90% with a minimum threshold of 85%. Physicians are informed of their results by letter, and criteria, resources, and/or provider education for improving documentation practices are provided as needed. Physicians who do not meet the 85% threshold are re-audited in approximately 6 months. For 2023, the average total provider scores ranged from 73% to 93%. Barriers and interventions were documented.

Network Adequacy Validation

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

Constellation Quality Health conducted a validation review of Humana's provider network following the CMS protocol titled, "EQR Protocol 4: Validation of Network Adequacy." This protocol validates the health plan's provider network to determine if the CCO is meeting network standards defined by the State. To validate Humana's network, the following information was requested and reviewed:

- Member demographics, including total enrollment and distribution by age ranges, sex, and county of residence.
- Geographic access assessments, network development plans, enrollee demographic studies, population needs assessments, provider-to-enrollee ratios, in-network and out-of-network utilization data, provider panel size limitations.
- A complete list of network providers.

- The total numbers of unique primary care and specialty providers in the network.
- A completed Provider Network File Questionnaire.
- Provider Appointment Standards and health plan policies.
- Provider Manual and Member Handbook.
- Sample of a provider contract.

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

Overall, Humana met the requirements of the Network Adequacy Validation. The following is an overview of the results for each activity.

Provider Network File Questionnaire

Constellation Quality Health reviewed the Provider Network File Questionnaire (PNFQ). Humana uses APEX as the business workflow system and updates the member-facing Provider Directory daily.

Availability of Services

42 CFR § 10(h), 42 CFR § 438.206(c)(1), 42 CFR § 438.214, 42 CFR § 457.1230(a), 42 CFR § 457.1230(b), 42 CFR § 457.1233 (a)

The 2023 Humana Healthy Horizons® in South Carolina Annual Network Development Plan (Network Development Plan) provides an overview of the plan to maintain and grow the SC provider network. Issues noted in this document include:

- Page 5 includes "Prior Year Network Analysis" but the first paragraph under the heading states, "In 2023-2023, Humana continued to focus on network adequacy, expansion, and retention." Onsite discussion confirmed this was a typographical error.
- Page 10 includes the heading, "Single Case Agreements (Member Specific Letter of Agreements)" that contains incomplete information.

Geographic access standards are documented in Policy SC.NNO.004, Provider Network Availability and Access, and in the 2023 Network Development Plan, and are compliant with contractual requirements. Processes for monitoring network adequacy are found in Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting. Humana monitors its network for gaps and opportunities to close gaps using Geo Access mapping, member satisfaction survey results, analysis of complaints, etc. The Network Adequacy Analytic team runs a weekly adequacy report and sends it to the SC Network Team to identify gaps, determine the severity of identified gaps, and develop interventions by reviewing the enrollment file and identifying any

available providers. Humana contacts identified available providers to discuss contracting with Humana. Humana notifies SCDHHS in writing of all instances of network failure (gaps) for a provider specialty and county, and as needed, includes a plan of action to address identified gaps. Constellation Quality Health recommends that Humana revise Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, to define the network gap categories that are referenced in the policy.

The South Carolina Medicaid Network Adequacy Report (updated November 14th with data as of October 12th) lists the correct time/distance parameters for PCPs. County-by-county access is documented. No network gaps were identified for PCPs (100% for all counties) and pediatrics providers (one county at 99.6% and the remainder at 100%). The document confirms Humana contracts with all required Status 1 provider types. For specialty providers, goals were met for all required Status 1 specialty types except Occupational Therapy in two counties.

Appointment access standards are appropriately documented in Policy SC.NNO.004, Provider Network Availability and Access, and in the 2024 Provider Manual. As noted in Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, Humana monitors provider compliance with appointment access standards through CAHPS Surveys, Member Complaints, Annual Provider Access and Availability Surveys, and out-of-network requests. Humana may place providers who are noncompliant with the availability standards on a corrective action plan and monitor for improvement. If issues remain uncorrected, the provider may be terminated from the network.

Humana conducts annual Provider Access and Availability Surveys to assess provider compliance with appointment access standards. For the study conducted in June 2023, 315 provider groups were included in the study to assess compliance with routine, urgent care, and emergent care standards. The overall pass rate was 98.5%.

The online "find a doctor" tool and the PDF Provider Directories include all elements required by the *SCDHHS Contract, Section 3.12.5.1.1*. However, the online "find a doctor" tool did not include the contractually required statement that some providers may choose not to perform certain services based on religious or moral beliefs. See *Table 12: Previous Provider Directory QIP Items* for previously identified issues with the Provider Directory and the current status of the findings.

Table 12: Previous Provider Directory QIP Items

Standard	2023 EQR Findings	2024 EQR Findings
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)*		

Standard	2023 EQR Findings	2024 EQR Findings
2. The MCO maintains a provider directory that includes all requirements.	The online "Find a Doctor" tool displays all required Provider Directory elements. Each of the PDF versions of the Provider Directories included the following statements, which appear to be contradictory: • Page 8 states, "To find out which providers are not taking new patients, go to Humana's website or call Member Services." • Page 13 states, "Provider information is current as of the date listed on the cover. Below are the types of provider information you will find." … "Whether the provider is accepting new patients." • The PDF versions of the regional Provider Directories submitted by Humana do not include an indication of providers that are not accepting new patients. This is a requirement of both the *SCDHHS Contract, Section 3.13.5.1.1* and *42 CFR 438.10 (h) (1) (vi).* *Quality Improvement Plan: To comply with requirements of the SCDHHS Contract, Section 3.13.5.1.1, and 42 CFR 438.10 (h) (1) (vi), revise the PDF Provider Directories to include an indicator of any providers who are not accepting new patients.*	All issues noted during the 2023 EQR were found to be corrected.
Humana's Response: Humana has updated the PDF versions of the Provider Directories by removing the contradictory statement "To find out which providers are not taking new patients, go to Humana's website or call Member Services." Humana currently utilizes two indicators: Established Patient Only and Not Accepting Patients. An indicator of "Accepting New Patients" will be added to Humana's Provider Directories.		

The 2023 South Carolina Medicaid Quality Assessment and Performance Improvement Program Description addresses Culturally and Linguistically Appropriate Services (CLAS) and describes Humana's activities to eliminate barriers members may face related to race, ethnicity, socioeconomic status, education, language, and physical attributes. Humana implemented its CLAS Program in November of 2022. In November 2023, Humana achieved its first Health Equity Accreditation from NCQA. The Provider Manual addresses cultural competency and the expectation that services are provided in a culturally competent manner. Providers are directed to the website and to Provider Services to obtain a copy of the Cultural Competency Plan and additional cultural competency resources.

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, Constellation Quality Health conducted a provider access study that focused on PCPs. From a list of current providers supplied by Humana, a population of 2,005 unique PCPs was found. A sample of 173 providers was randomly selected to receive secret shopper calls. Attempts were made to contact the providers to ask a series of questions about the access members have to the providers. Calls were successfully answered 77% of the time (124 of 161) when omitting calls answered by voicemail messaging services. When compared to last year's results of 57%, this year's study rate had a significant increase ($p < .001$) in successful calls.

Table 13: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	Fisher's Exact p-Value
2023 Review	175	57%	<.001
2024 Review	173	77%	

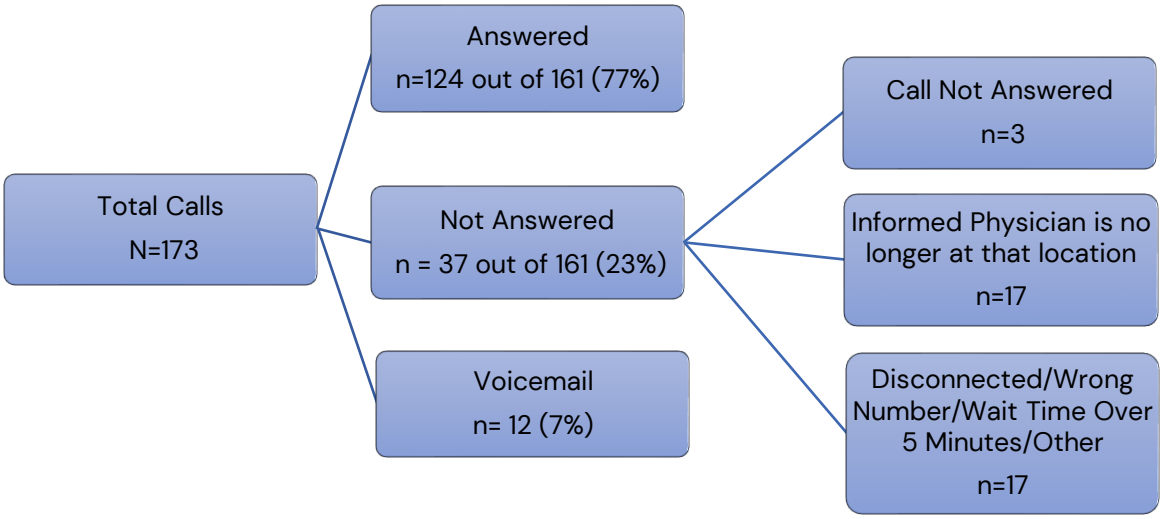
For calls that were not answered successfully (n= 37), 17 (46%) were due to the physician no longer being active at the location; 17 (46%) were due to a wrong number, hold time longer than five minutes, or busy signal, and three (8%) were due to the call not being answered.

Of 124 providers successfully contacted, 116 (94%) reported they accept Humana, three (2%) reported they do not accept Humana, and five (4%) were unsure if they accept Humana. Of the 116 that accept Humana, 99 (85%) reported they are accepting new patients and 17 (15%) are not accepting new patients.

A routine appointment was available within the contract requirements (30 days) for 82 (83%) of the 99 providers that are accepting new patients and outside the required timeframe for 12 providers (12%). For five of the 99 calls (5%), Constellation Quality Health was unable to obtain an appointment date due to the provider requesting more information, such as medical records or the insurance ID number of the member.

Results of the call study are displayed in *Figure 3: Telephonic Provider Access Study Results*.

Figure 3: Telephonic Provider Access Study Results



As noted in *Figure 4: Provider Services Findings*, 98% of the standards in the Provider Services section were scored as "Met."

Figure 4: Provider Services Findings

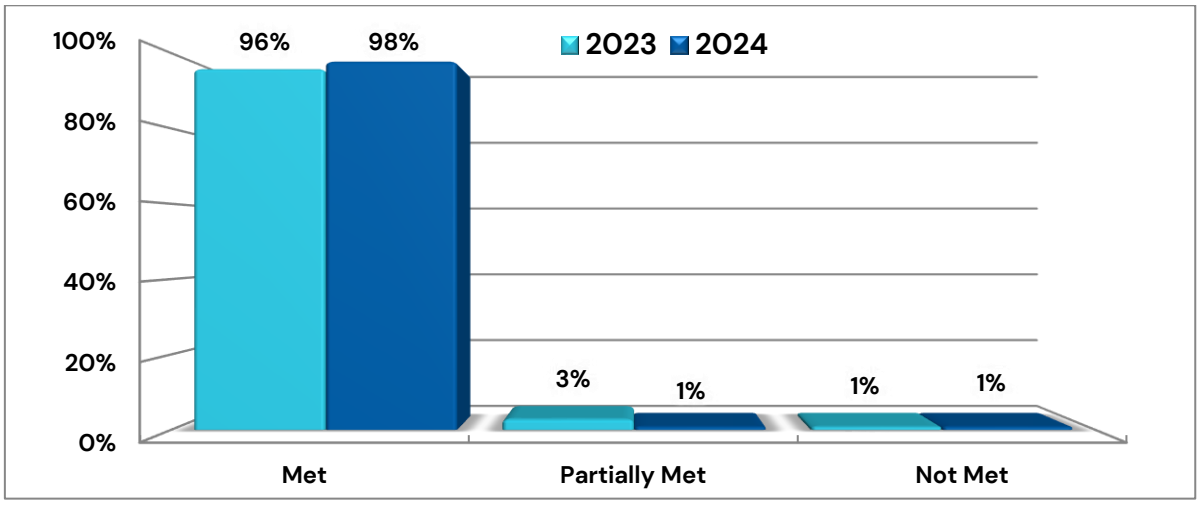


Table 14: Provider Services Comparative Data

Section	Standard	2023 Review	2024 Review
Credentialing and Recredentialing	Verification of information on the applicant, including: Additional Requirements for Nurse Practitioners	Met	Not Met
Adequacy of the Provider Network	The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy	N/A	Met
	The MCO conducts appointment availability and accessibility studies to assess provider compliance with appointment access standards	N/A	Met
	The MCO conducts appropriate activities to validate Provider Directory information	N/A	Met
	The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy"	N/A	Met
Provider Education	The MCO formulates and acts within policies and procedures related to initial education of providers	Not Met	Met
Provider Education	Initial provider education includes: Reassignment of a member to another PCP	Partially Met	Met

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

Table 15: Provider Services Strengths

Strengths	Quality	Timeliness	Access to Care
Credentialing processes and requirements are appropriately documented in policies and program descriptions.	✓		
Humana contracts with all required Status 1 provider types.			✓
No issues were noted in recredentialing files for practitioners and initial credentialing and recredentialing files for organizational providers.	✓		

Strengths	Quality	Timeliness	Access to Care
Appropriate processes are in place to suspend or terminate network participation when serious quality of care or service issues are confirmed.			✓
Humana uses appropriate time and distance standards for network providers, as documented in Policy SC.NNO.004, Provider Network Availability and Access, and in the 2023 Network Development Plan.			✓
When assessing network adequacy, Humana considers geographic access, member satisfaction survey results, analysis of complaints, etc.			✓
Humana has implemented a Culturally and Linguistically Appropriate Services program and educates providers about the program. Cultural competency resources are available on Humana's website.			✓
Humana achieved Health Equity Accreditation in November 2023.	✓		
Annually, Humana conducts a Provider Access and Availability Survey to assess provider compliance with appointment access standards.			✓
The successful call rate for the provider access study conducted by Constellation Quality Health improved from the previous year.			✓
Appropriate processes are in place for initial and ongoing provider education.	✓		
Humana communicates preventive health and clinical practice guidelines to providers and assesses compliance with the guidelines.	✓		
Provider compliance with medical record documentation standards is assessed through medical record audits.	✓		

Table 16: Provider Services Weaknesses, Recommendations, and Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
During the previous EQR, it was recommended that Humana attempt to recruit additional specialty providers to serve on the Credentials Committee. During the current EQR onsite, Humana reported that recruitment activities continue but have thus far been unsuccessful.	*Recommendation: Continue efforts to recruit specialty providers to serve on the Credentials Committee.*	✓		
The following issues were noted in the initial credentialing files: • One file was missing documentation of verification of admitting privileges or arrangements. • One file was missing documentation of verification of CLIA certification.	*Recommendation: Ensure all applicable practitioner credentialing files include verification of admitting privileges or arrangements and verification of CLIA certification.*			✓

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
• Two of the three initial credentialing files for nurse practitioners did not include the collaborative agreement between the nurse practitioner and the collaborating physician.	*Quality Improvement Plan: Collect collaborative agreements for nurse practitioners at initial credentialing and include in the credentialing file.*			
The following issues were noted in the 2023 Network Development Plan: • Page 5 includes "Prior Year Network Analysis" but the first paragraph under the heading states, "In 2023-2023, Humana …" Onsite discussion confirmed this was a typographical error. • Page 10 of the 2023 Network Development Plan includes the heading, "Single Case Agreements (Member Specific Letter of Agreements)" that contains incomplete information.	*Recommendation: Revise page 5 of the 2023 Network Development Plan to include the correct timeframe in the first paragraph under "Prior Year Network Analysis." Add the missing information regarding single case agreements to page 10 of the 2023 Network Development Plan.*	✓		
Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, addresses network gap classifications of low, mid-low, mid-high, and high, but does not define these categories. Post-onsite, Humana submitted a draft revision of Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, which defined the network gap categories.	*Recommendation: Finalize revisions to Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, which define the network gap categories.*			✓
During onsite discussion, Humana was informed that the contractually required statement that some providers may choose not to perform certain services based on religious or moral beliefs could not be located on the online "find a doctor" tool. Post-onsite, Humana acknowledged this finding.	*Quality Improvement Plan: Revise the online 'find a doctor" tool to include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. Refer to the SCDHHS Contract, Section 3.12.5.7.*			✓
Policy SC.QLT.006, Continuity and Coordination of Care, states, "Monitoring member's continuity of care allows Humana Healthy Horizons in South Carolina (HHH SC) to optimize medical care across the health care delivery system and improve member outcomes." However, the policy does not provide information about how this monitoring is conducted.	*Recommendation: Revise Policy SC.QLT.006, Continuity and Coordination of Care, to include Humana's processes for monitoring continuity of care between providers.*	✓		

II. PROVIDER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
II. PROVIDER SERVICES						
II A. Credentialing and Recredentialing *42 CFR § 438.214, 42 CFR § 457.1233(a)*						
1. The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	X					The 2023 Healthy Horizons in South Carolina CORE Credentialing & Recredentialing Program Description (Credentialing Program Description) provides an overview of the Credentialing Program. Policy SC.CDT.001 – Credentialing, Recredentialing, and Ongoing Sanction Monitoring, documents processes and requirements for initial and ongoing credentialing for 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					As noted in the Credentialing Program Description, Humana categorizes credentialing files as follows: • Category I files meet all established credentialing criteria, are approved daily by the Medical Director, and presented during the next Credentials Committee meeting. • Category II files do not meet all credentialing criteria and require review by the Credentials Committee.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						A Humana Medical Director chairs the Credentials Committee. Voting membership includes actively practicing network providers with unrestricted SC licensure and no role in Humana's management activities. Current voting members have specialties of family medicine, internal medicine, obstetrics and gynecology, and psychiatry. In addition, voting members include a pharmacist and a family medicine nurse practitioner. The Credentials Committee meets monthly, and the quorum is defined as the presence of 60% of voting members. Review of committee minutes from January through November 2023 confirmed the presence of a quorum at each meeting. No issues were identified with member attendance. During the previous EQR, it was recommended that Humana attempt to recruit additional specialty providers to serve on the Credentials Committee. During the current EQR onsite, Humana reported that recruitment activities continue but have thus far been unsuccessful.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Continue efforts to recruit specialty providers to serve on the Credentials Committee.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					
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	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
(State Board of Examiners for the specific discipline);						
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					One file was missing documentation of verification of admitting privileges or arrangements. *Recommendation: Ensure all applicable practitioner credentialing files include verification of admitting privileges or arrangements.*
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					One file was missing documentation of verification of CLIA certification. *Recommendation: Ensure all applicable practitioner credentialing files include verification of CLIA certification.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.16 Additional Requirements for Nurse Practitioners.			X			Two of the three initial credentialing files for nurse practitioners did not include the collaborative agreement between the nurse practitioner and the collaborating physician. *Quality Improvement Plan: Collect collaborative agreements for nurse practitioners at initial credentialing and include in the credentialing file.*
3.2 Receipt of all elements prior to the credentialing decision, with no element older than 180 days.	X					
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	X					
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.2.15 Additional Requirements for Nurse Practitioners.	X					
4.3 Review of practitioner profiling activities.	X					
5. The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues.	X					Policy SC.CDT.01, Credentialing, Recredentialing, and Ongoing Sanction Monitoring, states Humana may act to limit, reduce, restrict, suspend, revoke, or terminate a practitioner's network participation for "reasons relating to quality and that adversely affect, or could adversely affect, a patient's health or welfare." Policy QI-288-10, Provider Quality Review Process, describes processes followed to investigate and respond to quality-of-care issues.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					Humana conducts ongoing monitoring for provider sanctions through Council for Affordable Quality Healthcare's SanctionsTrack module. This weekly monitoring includes but is not limited to: • The List of Excluded individuals/Entities (LEIE) • The System for Award Management (SAM) publications • State Medicaid exclusion notifications When network providers are identified in the monitoring, credentialing staff confirm the identity of the sanctioned provider. If a match is confirmed, action is taken within 48 hours. The provider is notified of termination by certified letter and the provider is de-credentialed, the provider's contract is terminated, and a sanction code is added to the provider's record. The market is notified, and internal tracking is maintained. Policy SC.ETC.001, Ineligible Persons / Entities Screening Requirements, describes the process for routine monthly monitoring for provider sanctions and exclusions, and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						indicates that immediately upon discovery, Humana notifies the SCDHHS Division of Program Integrity of providers who have been debarred, suspended, or excluded from participation in Medicaid, Medicare, or any other program.
II B. Adequacy of the Provider Network *42 CFR § 438.206, 42 CFR § 438.207, 42 CFR § 10(h), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
1.The MCO conducts activities to assess the adequacy of the provider network, as evidenced by the following:						Humana provided a copy of the 2023 Humana Healthy Horizons® in South Carolina Annual Network Development Plan (Network Development Plan) that provides an overview of the plan to maintain and grow the SC provider network. Humana informed Constellation Quality Health that the 2024 Network Development Plan will be submitted by September 1, 2024. The 2023 Network Development Plan, page 5, includes "Prior Year Network Analysis" but the first paragraph under the heading states, "In 2023-2023, Humana continued to focus on network adequacy, expansion, and retention." Onsite discussion confirmed this was a typographical error. *Recommendation: Revise page 5 of the 2023 Network Development Plan to include*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the correct timeframe in the first paragraph under "Prior Year Network Analysis."
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					The time and distance standards for primary care providers (PCPs) stated in Policy SC.NNO.004, Provider Network Availability and Access, and in the 2023 Network Development Plan are compliant with contractual requirements. Humana's South Carolina Medicaid Network Adequacy Report displays results by county. The South Carolina Medicaid Network Adequacy Report (updated November 14th with data as of October 12th) lists the correct time/distance parameters for PCPs. County-by-county access is documented and all counties. The document indicates no network gaps were identified for PCPs (100% for all counties) and pediatrics providers (one county at 99.6% and the remainder at 100%).
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member	X					The South Carolina Medicaid Network Adequacy Report (updated November 14th with data as of October 12th) indicates Humana contracts with all required Status 1 provider types. Time and distance parameters used to measure geographic

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
may utilize an out-of-network specialist with no benefit penalty.						access for all provider types were compliant with contractual requirements. Goals were met for all required Status 1 specialty types except Occupational Therapy in two counties. Humana confirmed that members are assisted with getting needed care via implementation of single case agreements, etc.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, provides an overview of processes for monitoring network adequacy. As noted, Humana continuously monitors for network gaps and opportunities to close gaps using geo access mapping, CAHPS surveys, analysis of complaints, etc. As noted in the 2023 Network Development Plan, Humana uses the Quest Analytics Suite to analyze geographic access. In addition to geographic access monitoring, the Network Adequacy Analytic team runs a weekly adequacy report and sends it to the SC Network Team to identify gaps, determine the severity of identified gaps, and develop interventions by reviewing the enrollment file and identifying any available providers. Humana

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						contacts identified available providers to discuss contracting with Humana. Policy SC.NNO.016 states Humana notifies SCDHHS in writing of all instances of network failure (gaps) for a provider specialty and county. It further states that when mid-high and high network gaps are found, the response will include a plan of action that addresses and seeks to reduce identified gaps. The "Definitions" section of the policy states the Failure Severity Index Report indicates overall network adequacy performance and produces overall weighted scores that are categorized into four severity categories: low, mid-low, mid-high, and high. However, the policy does not define the four categories. Humana responded that the categories are defined by SCDHHS. Post-onsite, Humana submitted a draft revision of Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, which defined the network gap categories. *Recommendation: Finalize revisions to Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, which define the network gap categories.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs.	X					The 2023 South Carolina Medicaid Quality Assessment and Performance Improvement Program Description addresses Culturally and Linguistically Appropriate Services (CLAS) and describes Humana's activities to eliminate barriers members may face that are related to member race, ethnicity, socioeconomic status, education, language, and physical attributes. Activities include: • Collecting and validating membership race and ethnicity data. • Providing employee cultural competency, sensitivity, and health literacy education. • Ensuring member information is provided in alternate formats. • Distributing cultural competency resources and training to providers. • Monitoring risk assessments to ensure Humana meets members' diversity needs. • Using the Corporate Bold Gold Initiative, which focuses on the impact of food insecurity and social isolation and captures the impact on healthy days in communities. Humana Healthy Horizon's in South Carolina launched its CLAS Program in November of 2022. The program is guided by the NCQA Health Equity (HE) Standards through

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						development of the Culturally and Linguistically Appropriate Services (CLAS) Program Description, the CLAS Workplan and CLAS Program Evaluation. It was noted that in November 2023, Humana achieved its first Health Equity Accreditation. The 2024 Provider Manual addresses cultural competency and covers the expectation that services are provided in a culturally competent manner. The Provider Manual also states providers may obtain a copy of Humana's Cultural Competency Plan at no cost by contacting Provider Services. It also provides links to view the document online and to cultural competency training materials.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					The 2023 Network Development Plan describes processes followed to address network gaps. The SC contracting team reviews weekly adequacy reports for gaps, researches the severity of gaps and how they can be closed, and contacts any identified providers for to discuss contracting with Humana. Single case agreements are implemented as needed with non-participating providers to allow members to get care. Humana notifies SCDHHS of "failure" for specialties and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						counties, including a plan of action when applicable. Page 10 of the 2023 Network Development Plan includes the heading, "Single Case Agreements (Member Specific Letter of Agreements)" that contains incomplete information. *Recommendation: Add the missing information regarding single case agreements to page 10 of the 2023 Network Development Plan.*
1.6 The MCO maintains provider and beneficiary data sets to allow monitoring of provider network adequacy.	X					Constellation Quality Health reviewed the Provider Network File Questionnaire (PNFQ). Humana uses APEX as the business workflow system and updates the member-facing Provider Directory daily.
2. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
2.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Appointment access standards are appropriately documented in Policy SC.NNO.004, Provider Network Availability and Access, and in the 2024 Provider Manual.
2.2 The MCO conducts appointment availability and accessibility studies to	X					Policy SC.NNO.016, Network Availability and Access Monitoring and Reporting, states Humana monitors provider compliance

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
assess provider compliance with appointment access standards.						with appointment access standards through CAHPS surveys, member complaints, annual Provider Access and Availability Surveys, and out-of-network requests. Humana may place providers who are noncompliant with the availability standards on a corrective action plan and monitors for improvement. If issues remain uncorrected, the provider may be terminated from the network. An annual Provider Access and Availability Survey is conducted by making calls to providers to assess provider compliance with appointment access standards. For the study conducted in June 2023, 315 provider groups were contacted across pediatrics, primary care, specialty, and behavioral health providers to assess compliance with routine, urgent care, and emergent care standards. The overall pass rate was 98.5%.
2.3 The MCO regularly maintains and makes available a Provider Directory that includes all required elements.		X				The online "find a doctor" tool and the PDF Provider Directories include all elements required by the *SCDHHS Contract, Section 3.12.5.1.1.* During onsite discussion, Humana was informed that the contractually required statement that some providers may

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						choose not to perform certain services based on religious or moral beliefs could not be located on the online "find a doctor" tool. Post-onsite, Humana acknowledged this finding. *Quality Improvement Plan: Revise the online 'find a doctor" tool to include the required statement that some providers may choose not to perform certain services based on religious or moral beliefs. Refer to the SCDHHS Contract, Section 3.12.5.7.*
2.4 The MCO conducts appropriate activities to validate Provider Directory information.	X					Onsite discussion revealed Humana's Data Verification Team and/or vendors conduct outreach campaigns, contacting each provider at least twice yearly to confirm and update provider contact information.
2.5 The Telephonic Provider Access Study conducted by Constellation Quality Health shows improvement from the previous study's results.	X					As part of the annual EQR process for Humana, a provider access study was conducted focusing on PCPs. A list of current providers was given to Constellation by Humana, from which a population of 2,005 unique PCPs was found. A sample of 173 providers was selected to receive the secret shopper calls. Attempts were made to contact the providers to ask a series of questions

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						regarding member access with the providers. Calls were successfully answered 77% of the time (124 of 161) when omitting calls answered by voicemail messaging services. When compared to last year's results of 57%, this year's study rate had a significant increase (p <.001) in successful calls. For calls that were not answered successfully (n= 37), 17 (46%) were due to the physician no longer being active at the location; 17 (46%) were due to a wrong number, hold time longer than 5 minutes, or busy signal, and 3 (8%) were due to the call not being answered. Of 124 providers successfully contacted, 116 (94%) reported they accept Humana, three (2%) reported they do not accept Humana, and five (4%) were unsure if they accept Humana. Of the 116 that accept Humana, 99 (85%) reported they are accepting new patients and 17 (15%) are not accepting new patients. A routine appointment was available within the contract requirements (30 days) for 82 (83%) of the 99 providers that are accepting new patients and outside the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						required timeframe for 12 providers (12%). For five of the 99 calls (5%), Constellation Quality Health was unable to obtain an appointment date due to the provider requesting more information, such as medical records or insurance number of the member.
6. The MCO's provider network is adequate and is consistent with the requirements of the CMS protocol, "Validation of Network Adequacy."	X					The State has established time and distance requirements for PCP, OB/GYN, and specialty providers. The methods used for assessment of network adequacy are reliable, including provider access studies and network adequacy time/distance assessments with Quest Analytics software. Internal audits are conducted to maintain accurate provider directories.
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					Processes for initial provider orientation are found in Policy SC.NNO.007, New Provider Orientation and Annual Training. As noted, Humana trains network providers to ensure their compliance with Medicaid policies, procedures, laws, and regulations. New provider orientation is conducted within 30 days of the letter of credentialing or the contract effective date. Provider orientation attendance is logged into the QuickbaseTM system.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Providers can access various training materials and other resources on Humana's provider website. The Provider Manual is a comprehensive resource for providers to obtain information necessary to function appropriately within Humana's network.
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					
2.2 Billing and reimbursement practices;	X					
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					
2.4 Procedure for referral to a specialist;	X					
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					
2.7 Medical record handling, availability, retention and confidentiality;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;	X					
2.11 Medical record documentation requirements.	X					
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Processes for ongoing provider orientation are found in Policy SC.NNO.007, New Provider Orientation and Annual Training. As stated in the policy, Humana ensures providers receive ongoing education to inform of essential information, and topics may include "provider requirements, member care expectations, changes in policies and procedures, billing, and issues resolution processes." Forums used for ongoing provider education include: • Printed materials such as the Provider Manual, newsletters, educational materials, mailings, faxes, bulletins, etc. • Humana's website, the Provider Portal, and Availity.com. • In-person, virtual, and/or web-based training sessions.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Town Hall/Public Forums in at least 4 regional locations throughout the state at least once a year. Providers are informed of the town hall sessions through faxes, email blasts, and in routine and ad hoc provider meetings. Records of attendance at ongoing provider education sessions are maintained.
II D. Preventive Health and Clinical Practice Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health and clinical practice guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					As noted in Policy SC.QTL.007, Clinical Practice Guidelines and Adherence–Medical and Behavioral Health, Humana adopts guidelines for physical and behavioral health conditions applicable to Humana's membership. The adopted guidelines are sourced from nationally recognized experts, such as the US Preventive Services Task Force, American Diabetes Association, American Psychological Association, etc. The Clinical Practice Guideline Physician Committee (CPGPC) meets twice yearly to review new and revised guidelines and makes recommendations to the Corporate Quality Improvement Committee for approval and adoption. The approved

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						guidelines are presented to the market's Quality Assurance Committee (QAC) and posted on the website. During the previous EQR, it was noted that there were no SC physicians on the corporate CPGPC. During the current EQR, Humana reported that a SC physician is now a member of the CPGPC.
2. The MCO communicates the preventive health and clinical practice guidelines to providers, along with the expectation that they will be followed for MCO members.	X					The Provider Manual states PHGs and CPGs are disseminated to all providers through Provider Manual updates, newsletters, and Humana's website. Providers may contact Provider Relations Representatives or the Care Management Department to request copies of the guidelines. Through the Provider Manual, Humana encourages providers to use the guidelines as decision-making aids about appropriate care and to promote positive member outcomes. It further indicates providers hold the ultimate responsibility to determine the best treatment for each member.
3. The guidelines include, at a minimum, the following if relevant to member demographics:						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
3.2 Recommended childhood immunizations;	X					
3.3 Pregnancy care;	X					
3.4 Adult screening recommendations at specified intervals;	X					
3.5 Elderly screening recommendations at specified intervals;	X					
3.6 Recommendations specific to member high-risk groups;	X					
3.7 Behavioral health services.	X					
II E. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					Policy SC.QLT.006, Continuity and Coordination of Care, states, "Monitoring member's continuity of care allows Humana Healthy Horizons in South Carolina (HHH SC) to optimize medical care across the health care delivery system and improve member outcomes." However, the policy does not provide information about how this monitoring is conducted.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The process for conducting annual evaluations of continuity and coordination of care for medical and behavioral health providers was noted in the 2023 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description. Humana staff confirmed this is done annually. *Recommendation: Revise Policy SC.QLT.006, Continuity and Coordination of Care, to include Humana's processes for monitoring continuity of care between providers.*
II F. Practitioner Medical Records						
1. The MCO formulates policies and procedures outlining standards for acceptable documentation in member medical records maintained by primary care physicians.	X					Policy SC.QLT.010, Medical Record Review, describes the Medical Record Documentation Review (MRDR) process. Sample sizes for the MRDR are based on compliance needs and the size of the market's membership. The MRDR is conducted at least bi-annually by a Quality Compliance Nurse, with results presented to the market Quality Assurance Committee (QAC) annually. The goal score is 90% with a minimum threshold of 85%.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Physicians are informed of their results by letter, and the results may include the MRDR criteria, resources, and/or provider education for improving documentation practices. Physicians who do not meet the 85% threshold are re-audited in approximately 6 months.
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Policy SC.QLT.010, Medical Record Review, defines medical record documentation standards and expectations for medical record-keeping practices. The Provider Manual appropriately documents medical record documentation elements.
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					QAC minutes from 11/14/23 include an overview of 2023 Medical Record Review Results. The average total provider scores ranged from 73% to 93%. Barriers and interventions were documented.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

C. Member Services

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

Constellation Quality Health's review of Member Services includes member rights and responsibilities, member education, enrollment and disenrollment processes, member satisfaction survey validation, and processes for handling and resolving member grievances.

Policy SC.MKA.004, Member Rights and Responsibilities, Humana's QuickStart Guide, Member Handbook, Provider Manual, and website summarize member rights and responsibilities.

Humana sends Welcome Kits, including member educational materials, to new members no later than 14 calendar days from receipt of enrollment data. The Member Handbook outlines covered services, pharmacy information, copayments, prior authorization requirements, etc. Members are notified of changes in services and benefits in writing 30 days before the effective date of the change.

Policy SC.MKT.001, Marketing Policy, states that "All written materials are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the potential Member's or Member's special needs with disabilities or limited English reading proficiency." The Member Handbook provides instructions for obtaining a copy of the Member Handbook and other member materials in large print or in alternate languages if needed, which is reiterated to members in Humana's Annual Benefits Letter.

The Customer Service number and hours of operation are provided throughout the Member Handbook and website. Members are also informed of the availability of the 24/7 Nurse Advice Line.

Policy SC.MCC.008, Disenrollment Requests, describe Humana's process for requesting disenrollment. The following table outlines previous EQR findings and corrective action steps taken regarding Humana's disenrollment process. No issues were identified for the current EQR.

Table 17: Previous Disenrollment Policy Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*		
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	Policy SC.MCC.008, Disenrollment, outlines steps taken by Customer Care Advocates (CCAs) when a member verbalizes a wish to disenroll from the health plan. The policy states that the Customer Care Advocate will	Policy SC.MCC.008, Disenrollment Requests, has been revised remove the requirement that members

Standard	2023 EQR Findings	2024 EQR Findings
	"offer or attempt to resolve any of the members' reasons for dissatisfaction and appropriately log any issues as a grievance." The policy continues to state that "CCA will determine if the member previously filed a grievance about their request to disenroll. If a grievance was not previously filed, CCA will document the reason the member wants to disenroll and advise the member that a grievance must be filed to disenroll from the plan." The *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5* address requirements for member disenrollment requests both with and without cause. There is no contractual requirement that members must file a grievance with the health plan in order to request disenrollment. *Quality Improvement Plan: Revise Policy SC.MCC.008 and internal processes to remove the requirement that a member must file a grievance in order to request disenrollment.*	must file a grievance in order to request disenrollment.
Humana Response: Humana has revised policy SC.MCC.008-Disenrollment Requests, to remove the statement that a member must file a grievance to request disenrollment. 6/9/2023: Humana's policy SC.MCC.008 – Disenrollment Requests has been updated by removing incorrect language in the Scope and Procedures sections of the policy.		

Member Satisfaction Survey

Humana contracts with a vendor, Press Ganey, to conduct the member satisfaction surveys. For MY2022, the adult response rate was 12.6% (169 out of 1,336), which is an improvement from the previous year's response rate of 5.1%. For year-over-year trending, improvement was demonstrated in rating of health plan, rating of health care, and flu vaccine. The largest decline was for getting care quickly. The child response rate was 6.8% (93 out of 1,359 surveys), which is a decline from the previous year's rate of 7.9%. Improvement occurred for rating of health plan, getting needed care, customer service, rating of health care, getting care quickly, and how well doctors communicate. The largest decline was noted for the rating of specialists. The child CCC response rate was 6% (84 of 1406), which is an improvement over the previous year's rate of 5.4%. For the CCC population, the highest rated domain was getting care quickly. The improvement and decline evaluation are not performed due to several domains having a sample size of zero reported last year.

Grievances

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

Policy SC.MCC.005, Member Grievances and Appeals, Policy SC.GAA.001, South Carolina Medicaid Grievance and Appeal Policy, the Member Handbook, the Provider Manual, and the website describe processes for handling grievances. Grievance terminology is defined and information about the process to file verbal and written grievances is included. Discrepancies were noted in the timeframe for grievance acknowledgement in Policy SC.MCC.005, Member Grievances and Appeals, the Member Handbook and Provider Manual. Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, does not define the timeframe for grievance acknowledgement. Additionally, the grievance acknowledgement letters reviewed this year, along with the Grievance Acknowledgment Letter Template, do not indicate that a grievance may be filed if the member disagrees with an extension as required by the *SCDHHS Contract, Section 9.1.6.1.4* and *9.1.6.1.5*. Grievances are logged and categorized appropriately, with trends reported quarterly to the Quality Assurance Committee.

Of the sample of grievance files reviewed, the majority were acknowledged and resolved timely. However, three files were closed with significant time remaining, and members were instructed to contact the MCO to provide further information. One grievance was closed significantly beyond the 90-day resolution timeframe. Humana staff reported that coaching and additional training were provided to the reviewers assigned to these grievances. Humana reported that their internal process for requesting additional information from members is to make three attempts to contact the member, using at least two formats (i.e., letter and telephone).

Issues identified during the previous EQR and the current status of those issues are outlined in the following table.

Table 18: Previous EQR Grievance Policy Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
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:	Policy SC.GAA.001, page 10 of the Member Handbook defines a grievance as, "an expression of dissatisfaction about any matter other than an Action." The term "action" is outdated, and the correct term is "adverse benefit determination." Refer to *SCDHHS Contract, Section 9* and *42 CFR 438.400 (b)*. It was noted that page 63 of the Member Handbook uses appropriate verbiage when defining a grievance.	The definition of a grievance was appropriately indicated in Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, the Member Handbook (pg. 10), and on Humana's website.

Standard	2023 EQR Findings	2024 EQR Findings
1.1 The definition of a grievance and who may file a grievance;	Humana's website defines a grievance as, "a formal complaint or dispute expressing dissatisfaction with any aspect of the operations, activities or behavior of Humana or its providers." As written, this definition is incomplete, as it omits the language "other than an adverse benefit determination." The term "grievance" is correctly defined on page 33 of the Provider Manual. Policy SC.GAA.001, the Member Handbook, and the Provider Manual correctly describe who can file a grievance and state a grievance can be filed at any time. *Quality Improvement Plan: Correct the definition of a grievance in Policy SC.GAA.001, the Member Handbook (page 10), and on Humana's website.*	
Humana's Response: Humana has revised policy SC.GAA.001-Medicaid Grievance and Appeal, updated the Member Handbook (page 10), and Humana's website to correct the definition of a grievance per the SC MCO contract and *42 CFR 438.400 (b)*.		

For this EQR, 94% of the Member Services standards were scored as "Met" and 6% were scored as "Partially Met."

Figure 5: Member Services Findings

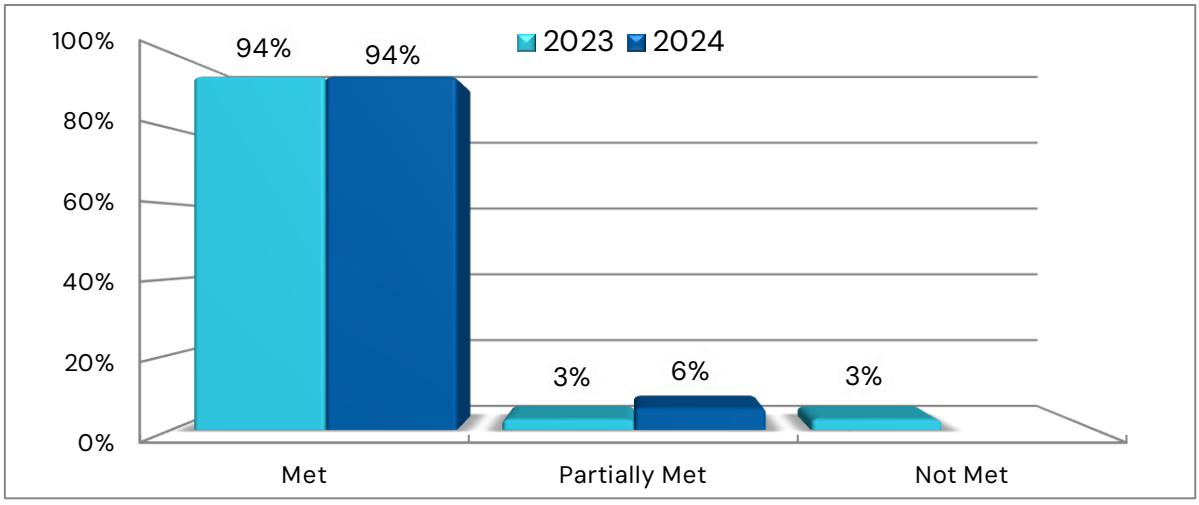


Table 19: Member Services Comparative Data

Section	Standard	2023 Review	2024 Review
Grievances	The definition of a grievance and who may file a grievance	Partially Met	Met

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

Table 20: Member Services Strengths

Strengths	Quality	Timeliness	Access to Care
Of the grievance files reviewed for the current EQR, all grievances were acknowledged timely, and the majority of the grievances were resolved timely.		✓	

Table 21: Member Services Weaknesses, Recommendations, and Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Discrepancies were noted in the timeframe for grievance acknowledgement, as follows: • Policy SC.MCC.005, Member Grievances and Appeals, states the grievance acknowledgement timeframe is 10 calendar days. • Policy and Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, does not define the timeframe for grievance acknowledgement. • The Member Handbook and Provider Manual state the grievance acknowledgement timeframe is indicate that members are informed a letter will be sent within five business days from the date of receipt of a grievance.	*Quality Improvement Plan: Revise the documents listed above to consistently document the timeframe for grievance acknowledgement. Include the acknowledgement timeframe in Policy SC.GAA.001,*		✓	
Grievance acknowledgement letters do not indicate that a grievance may be filed if the member disagrees with an extension as referenced in the *SCDHHS Contract, Section 9.1.6.1.4* and *9.1.6.1.5*.	*Quality Improvement Plan: Revise the Grievance acknowledgement letters to indicate that a grievance may be filed if the member disagrees with an extension of the grievance resolution timeframe, as noted in the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Three grievance files were closed with significant time remaining, with instructions for the member to contact the health plan to provide further information.	*Quality Improvement Plan: Establish processes or training to ensure that grievances are not closed with significant time remaining when additional information is needed.*		✓	

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy SC.MKA.004, Member Rights and Responsibilities, lists rights and responsibilities for Humana's members.
2. Member rights include, but are not limited to, the right:	X					
2.1 To be treated with respect and with due consideration for dignity and privacy;						
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.5 To be able to request and receive a copy of the member's medical records and request that it be amended or corrected as specified in Federal Regulation (*45 CFR Part 164*);						
2.6 To freely exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO and its providers or the Department treat the Medicaid MCO Member.						
III B. Member MCO Program Education *42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)*						
1. Members are informed in writing within 14 calendar days from the MCO's receipt of enrollment data of all benefits and MCO information including:	X					Policy SC.MKT.001, Marketing and Member Communication, states Humana sends Welcome Kits to new members no later than 14 calendar days from receipt of enrollment data.
1.1 Benefits and services included and excluded in coverage;						
1.1.1 Direct access for female members to a women's health specialist in addition to a PCP;						
1.1.2 Access to 2nd opinions at no cost, including use of an out-of-network provider if necessary.						
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						
1.7 Policies and procedures for accessing specialty care;						
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.11 Procedures for disenrolling from the MCO;						
1.12 Procedures for filing grievances and appeals, including the right to request a State Fair Hearing;						
1.13 Procedure for obtaining the names, qualifications, and titles of the professionals providing and/or responsible for care and of alternate languages spoken by the provider's office;						
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
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;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						
1.20 A description of advance directives, how to formulate an advance directive, and how to receive assistance with executing an advance directive;						
1.21 Information on how to report suspected fraud or abuse;						
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					Members are informed annually in the Annual Benefits Letter of the availability of member materials.
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 SC.MKT.001, Marketing Policy, states that "All written materials are available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the potential Member's or Member's special needs with disabilities or limited English reading proficiency."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Members are informed of the availability of the 24/7 Nurse Advice Line. Additionally, the Customer Service number and hours of operation are provided throughout the Member Handbook and website.
III C. Member Enrollment and Disenrollment *42 CFR § 438.56*						
1. The MCO enables each member to choose a PCP upon enrollment and provides assistance if needed.	X					
2. MCO-initiated member disenrollment requests are compliant with contractual requirements.	X					Policy SC.MCC.008, Disenrollment Requests, describes Humana's process for requesting disenrollment.
III D. Preventive Health and Chronic Disease Management Education						
1. The MCO informs members of available preventive health and disease management services and encourages members to utilize these services.	X					The Member Handbook provides members with information about care management, disease management, and preventive health programs.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					Information about Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services is included in the Member Handbook.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
and tracks the participation of pregnant members in recommended care.						
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					Humana contracts with Press Ganey, a certified vendor, to conduct the adult and child member satisfaction surveys. Press Ganey acquired SPH analytics.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					
1.2 The availability and accessibility of health care practitioners and services;	X					
1.3 The quality of health care received from MCO providers;	X					
1.4 The scope of benefits and services;	X					
1.5 Claim processing procedures;	X					
1.6 Adverse MCO claim decisions.	X					
2. The MCO analyzes data obtained from the member satisfaction survey to identify quality issues.	X					Press Ganey summarizes and details results of the member satisfaction surveys. The Quality Assurance Committee meeting minutes for August 2023 reflected analysis of survey data.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Action steps to address satisfaction concerns were demonstrated in an evaluation, which included barriers, interventions, and recommendations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4. The MCO reports the results of the member satisfaction survey to providers.	X					Until there is a trending analysis available with reliable data for the member satisfaction surveys, Humana is informing providers during touchpoints about CAHPS surveys, but not giving results due to low reliability of the survey rates. Once a trending analysis is available, results will be reported to providers.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					Quality Assurance Committee meeting minutes showed discussion of CAHPS adult and child surveys.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to:	X					Policy SC.MCC.005, Member Grievances and Appeals, Policy SC.GAA.001, South Carolina Medicaid Grievance and Appeal Policy, the Member Handbook, the Provider Manual, and Humana's website describe processes for handling grievances.
1.1 The definition of a grievance and who may file a grievance;	X					
1.2 Procedures for filing and handling a grievance;		X				Discrepancies were noted in the timeframe for grievance acknowledgement, as follows: • Policy SC.MCC.005, Member Grievances and Appeals, states the grievance acknowledgement timeframe is 10 calendar days.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, does not define the timeframe for grievance acknowledgement. • The Member Handbook and Provider Manual state the grievance acknowledgement timeframe is within five (5) business days from the date of receipt of a grievance. *Quality Improvement Plan: Revise the documents listed above to consistently document the timeframe for grievance acknowledgement. Include the acknowledgement timeframe in Policy SC.GAA.001* Grievance acknowledgement letters do not indicate that a grievance may be filed if the member disagrees with an extension as required by the *SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5*. *Quality Improvement Plan: Revise the Grievance acknowledgement letters to indicate that a grievance may be filed if the member disagrees with an extension of a grievance resolution timeframe, as required by the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 Timeliness guidelines for resolution of a grievance;	X					
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.		X				Three grievance files were closed with significant time remaining, with instructions for the member to contact the health plan to provide further information. *Quality Improvement Plan: Establish processes or training to ensure that grievances are not closed with significant time remaining when additional information is needed.*
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Grievances are logged and categorized appropriately. Trends are reported quarterly as reflected in the minutes of the Quality Assurance Committee.
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

D. Quality Improvement

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

Humana's Quality Improvement (QI) Program's focus is to monitor, evaluate, and facilitate improvement in the quality of health care services provided to members. The 2023 Quality Assessment and Performance Improvement Program Description describes the QI Program that Humana has implemented to help achieve the goals that are outlined in the document. As noted in *Table 22: 2023 EQR Quality Improvement Deficiency*, Constellation Quality Health found the QI Program Description lacked information regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships). Humana addressed this deficiency and added a section in the Program Description and included a staffing structure, responsibilities, and resources.

Table 22: 2023 EQR Quality Improvement Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
IV A. The Quality Improvement (QI) Program		
1. The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members.	Humana submitted the 2022 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description. This program description provides an overview of the QI program Humana has in place to monitor, evaluate, and facilitate improvement in the quality of health care services provided to members. The program's goals, scope, and methodologies are included. The program description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships). Humana addressed this during the onsite and indicated there were currently five staff assigned to the QI Program as well as the Medical Director's involvement. The organizational chart for the Quality Department was provided after the onsite. *Quality Improvement: Update the QI Program Description and include the program's structure related to the staff assigned to the QI Program and their responsibilities.*	In the 2023 QI Program Description, a section was added that included the program's structure, staff, and responsibilities.
Humana's Response: Humana hired additional staff for 2023. The QI Program Description has been updated to include the structure, staff, and organizational chart for the Quality Department.		

Members and providers are informed of the QI Program via Humana's website, the Member Handbook, and the Provider Manual. Humana's website states "We want you to feel confident that you made the right choice in your plan. View the HEDIS State of Health Care Quality Report:" and a link was provided for the HEDIS State of Health Care Quality Report. This link takes the user to the State of Health Care Quality Report on the NCQA website. However, this report was a summary report of performance measure results for commercial, Medicare and Medicaid health plans and not health plan specific.

Humana develops a work plan annually that includes measurable goals and objectives based on the health plan's previous year's annual evaluation. The 2022 and 2023 QI Work Plans were provided. The work plans included the quality improvement activities, the goals and objectives for each activity, the responsible party, and the expected completion date. The work plans lacked detail regarding any updates or changes when reports were not presented to the applicable committee. Some goals noted in the work plans were not the goals that were reported.

The Quality Assurance Committee (QAC) is the local committee responsible for providing operational oversight of the QI Program. The 2023 Quality Assurance Committee Charter provided an overview of the committee's purpose, membership, responsibilities, meeting requirements, and reporting. The Committee Charter includes the specifics for voting and non-voting members of the committee. This committee is chaired by the Chief Medical Officer and co-chaired by the Quality Improvement Lead. Other members of the committee include directors and other representatives from the health plan's management staff. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. The committee meeting minutes demonstrated Humana had recruited two network providers, a pediatrician and an OB/GYN provider. The pediatrician attended the meetings held in 2023 and resigned from the committee in January 2024. The OB/GYN physician only attended one meeting (May 2023). It was discussed onsite, and Humana indicated a primary care physician had been recruited and will be added to the committee in May 2024. Additional information was submitted following the onsite. It was noted that the August 2023 attendance for the voting members had changed. The August 2023 meeting minutes provided after the onsite documented the pediatrician was noted as absent and the OB/GYN was noted as present. This additional information did not address the lack of a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1*. As noted in *Table 23: Quality Improvement Committee 2023 EQR Deficiency*, this was an issue identified during the previous EQR and not corrected.

Table 23: Quality Improvement Committee 2023 EQR Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
IV B. Quality Improvement Committee		
2. The composition of the QI Committee reflects the membership required by the contract.	The SC Medicaid Medical Director serves as the chair for the QAC. Per the committee charter, voting members include various members of Humana's Management Team and participating network providers. Non-voting members include other staff representing additional business areas of the organization. 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 committee minutes for meetings held in 2022 did not include any participating network practitioners. The minutes for the meeting held in January 2023 documented one network practitioner and one physician consultant not participating in Humana's network had been added. This was an issue identified during the previous EQR and not corrected. *Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.*	The lack of a variety of participating network providers as required by *SCDHHS Contract, Section 15.3.1.2* continues to be an issue for Humana. Additional information was submitted following the onsite, however the composition of the committee still does not meet the contract requirements.
Humana's Response: Humana recruited an in-network Pediatrician in Q1 2023 due to the efforts in Q4 2022. Humana's Market Chief Medical Officer (CMO) continues to outreach to our credentialing and network teams for further recruitment efforts. Due to those efforts, the market was able to recruit an additional in-network physician of OB/Gyn specialty for the 2nd QTR 2023 QAC. Due to the COVID pandemic, it has been difficult to recruit providers because of the provider's staffing issues within the practice or facility post-pandemic. 6/9/2023: Humana has updated the Quality Assurance Committee agendas by listing voting and non-voting committee members on pages 1 and 2.		

Minutes are documented for each meeting and presented to the committee for review and approval at the next scheduled meeting. The QAC 2023 Charter indicates a quorum of fifty percent of the voting members plus one must be present for committee action and voting members are expected to attend each meeting or appoint a representative in their absence. The committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings. Also, the August 2023 meeting minutes indicated the Committee Chair was absent. However, the minutes reflected the meeting was called to order by the Committee Chair.

After the onsite, Humana submitted another copy of the QAC meeting minutes for meetings held in 2023. It was noted for the August 2023 meeting that the voting members' attendance had changed. The Compliance Lead, the Clinical Pharmacy Director, and the OB/GYN External Physician were marked as present in the committee meeting minutes submitted after the onsite. These voting members were noted as absent in the meeting minutes submitted with the desk materials. Also, an external physician (pediatrician) was noted as absent in the meeting minutes submitted after the onsite. There was no documentation indicating why the attendance was changed and the minutes amended.

Humana requires providers to actively participate in the QI activities. Provider performance is shared via the Stars Quality Report and PCPs can participate in the Primary Care Provider Recognition Program Report.

At least annually, Humana assesses the effectiveness of the quality program. Last year, Humana provided the 2021 – 2022 QI Program Evaluation. This evaluation lacked the results and analysis for some of the activities, and there were errors noted for some of the goals. *Table 24: Annual QI Evaluation 2023 EQR Deficiency* provides an overview of this deficiency with Humana's response.

Table 24: Annual QI Evaluation 2023 EQR Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
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.	Annually, Humana completes an evaluation of the previous year's QI Program to determine the effectiveness of the program. Humana provided the 2021 – 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation for review. The QI Program Evaluation included the outcomes of some of the activities completed or underway during 2021 and 2022. A barrier analysis and recommendations for 2023 to overcome those barriers were also included. The evaluation lacked the results and analysis for the following activities: • Timely Access/PCP Wait Times • Network Adequacy (time and distance) • The Utilization Management Overview Data (Over and Underutilization) • Delegation Oversight monitoring Also, the goal for measuring the credentialing and recredentialing activities appeared to be	The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation was provided for this EQR. This evaluation provided the annual analysis of Humana's QI program with barriers, interventions, and conclusions or recommendations for each activity. Constellation Quality Health found the previously identified issues were not corrected in the evaluation received for this EQR.

Standard	2023 EQR Findings	2024 EQR Findings
	incorrect. The goal listed in the background information indicated the goal for completing the credentialing process is 30 days. The results table listed the goal as 90 days and the goal noted in the 2022 QI work plan was listed as 60 days. The graph on page 20 of the QI Program Evaluation only included the results of the recredentialing activities. These deficiencies were discussed during the onsite. Staff explained the QI Program Evaluation was created for accreditation purposes and did not contain 12 months of data. *Quality Improvement Plan: Correct the errors in the QI Program Evaluation and include the results of all activities completed and/or an update for the ongoing activities.*	
Humana Response: The 2023 QI Program Evaluation will demonstrate 12 months of program analysis and include all items with well-defined goals and missing reports that were identified in the 2021-2022 report (Timely Access/PCP Wait Times, Network Adequacy (time and distance), The Utilization Management Overview Data (Over and Underutilization), and Delegation Oversight monitoring). The date for the Evaluation is August 2023.		

The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation was provided for this EQR. This evaluation provided the annual analysis of Humana's QI Program with barriers, interventions, and conclusions or recommendations for each activity. Constellation Quality Health found the previously identified issues were not corrected in the evaluation received for this EQR. There were issues with missing data or results and incorrect goals being measured. Those included:

- The Delegation Oversight activity was not included in the evaluation. This was an issue noted during the previous EQR and not corrected.
- Page 33, Section D, Monitoring and Improving Patient Safety indicates the goal for this activity is set at:
  - 80% of cases are closed or sent to Peer Review Committee within 90 days
  - 90% of cases are closed or sent to Peer Review Committee within 120 days

  However, the goal in the 2022 QI Work Plan for this activity is listed as 90% of the cases are closed or sent to the Peer Review Committee within 120 days, and 95% within 160 days.
- The tables on pages 38 and 39 note there were no Complaints, Grievances, and Appeals for 2022 related to access. However, the Grievance and Appeal section of the evaluation, page 47,

noted several grievances in the second, third, and fourth quarters of 2022 related to provider access issues.

- Page 47 states, "there were no Behavioral Health Grievances or Appeals for the 2022 year." However, under the Qualitative Analysis section, grievances related to behavioral health are noted in the second and third quarters of 2022.
- The graph on page 86 was upside down.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

Constellation Quality Health conducted a validation review of the HEDIS measures following the CMS protocol. This process assessed the production of these measures by the health plan to confirm reported information was valid.

Humana uses certified software (Cotiviti) for calculation of HEDIS rates. The rates were audited by the Dunwood Technology Services Group. The performance measure validation found that Humana was fully compliant with all HEDIS measures and met the requirements per *42 CFR §438.330 (c)* and *§457.1240 (b)*.

All relevant HEDIS performance measures (PMs) for the current measure year (2022) and the previous measure year (2021) are reported in *Table 25: HEDIS Performance Measure Results*. Due to all rates having at least one measurement year of unreliable rates with denominators less than 30, percentage point differences are not reported.

Table 25: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)			
BMI Percentile	85.71%*	71.05%	NA
Counseling for Nutrition	71.43%*	58.39%	NA
Counseling for Physical Activity	71.43%*	55.96%	NA
Childhood Immunization Status (cis)			
DTaP	NR	31.25%	NA
IPV	NR	43.75%	NA
MMR	NR	54.17%	NA
HiB	NR	43.75%	NA
Hepatitis B	NR	41.67%	NA
VZV	NR	54.17%	NA

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Pneumococcal Conjugate	NR	37.50%	NA
Hepatitis A	NR	52.08%	NA
Rotavirus	NR	33.33%	NA
Influenza	NR	6.25%	NA
Combination #3	NR	27.08%	NA
Combination #7	NR	25.00%	NA
Combination #10	NR	4.17%	NA
Immunizations for Adolescents (ima)			
Meningococcal	NR	50.00%	NA
Tdap/Td	NR	57.69%	NA
Combination #1	NR	50.00%	NA
Combination #2	NR	11.54%	NA
Human Papillomavirus Vaccine for Female Adolescents (hpv)	NR	11.54%	NA
Lead Screening in Children (lsc)	NR	35.42%	NA
Breast Cancer Screening (bcs)	33.33%*	0.00*	NA
Cervical Cancer Screening (ccs)	25.00%*	31.39%	NA
Colorectal Cancer Screening (COL)	NR	20.00%*	NA
Chlamydia Screening in Women (chl)			
Total	0.00%*	56.83%	NA
Effectiveness of Care: Respiratory Conditions			
Appropriate Testing for Children with Pharyngitis (cwp)			
Total	NR	82.35%	NA
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	NR	NR	NA
Pharmacotherapy Management of COPD Exacerbation (pce)			
Systemic Corticosteroid	100%*	78.79%	NA
Bronchodilator	100%*	75.76%	NA
Asthma Medication Ratio (amr)			
Total	100%*	NR	NA
Effectiveness of Care: Cardiovascular Conditions			
Controlling High Blood Pressure (cbp)	0%*	63.41%	NA
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	NR	0.00%*	NA
Statin Therapy for Patients With Cardiovascular Disease (spc)			
Received Statin Therapy - Total	100%*	100%*	NA
Statin Adherence 80% - Total	100%*	0.00%*	NA
Cardiac Rehabilitation (CRE)			
Cardiac Rehabilitation - Initiation (Total)	NR	0.00%*	NA
Cardiac Rehabilitation - Engagement1 (Total)	NR	0.00%*	NA

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Cardiac Rehabilitation - Engagement2 (Total)	NR	0.00%*	NA
Cardiac Rehabilitation - Achievement (Total)	NR	0.00%*	NA
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
HbA1c Poor Control (>9.0%)	100%*	49.72%	NA
HbA1c Control (<8.0%)	0.00%*	39.11%	NA
Eye Exam (Retinal) Performed	0.00%*	36.46%	NA
Blood Pressure Control (<140/90 mm Hg)	0.00%*	61.67%	NA
Kidney Health Evaluation for Patients With Diabetes (ked)			
Kidney Health Evaluation for Patients With Diabetes (Total)	NR	20.88%	NA
Statin Therapy for Patients With Diabetes (spd)			
Received Statin Therapy	NR	NR	NA
Statin Adherence 80%	NR	NR	NA
Effectiveness of Care: Behavioral Health			
Diagnosed Mental Health Disorders (dmh)			
Diagnosed Mental Health Disorders (Total)	NR	21.91%	NA
Antidepressant Medication Management (amm)			
Effective Acute Phase Treatment	NR	61.76%	NA
Effective Continuation Phase Treatment	NR	29.41%	NA
Follow-Up Care for Children Prescribed ADHD Medication (add)			
Initiation Phase	NR	50.00%*	NA
Continuation and Maintenance (C&M) Phase	NR	NR	NA
Follow-Up After Hospitalization for Mental Illness (fuh)			
Total - 30-Day Follow-Up	80.00%*	45.00%	NA
Total - 7-Day Follow-Up	60.00%*	27.50%	NA
Follow-Up After Emergency Department Visit for Mental Illness (fum)			
Total - 30-Day Follow-Up	75.00%*	40.32%	NA
Total - 7-Day Follow-Up	25.00%*	29.03%	NA
Diagnosed Substance Use Disorders (DSU)			
Diagnosed Substance Use Disorders - Alcohol (Total)	NR	2.81%	NA
Diagnosed Substance Use Disorders - Opioid (Total)	NR	1.70%	NA
Diagnosed Substance Use Disorders - Other (Total)	NR	3.88%	NA
Diagnosed Substance Use Disorders - Any (Total)	NR	6.30%	NA
Follow-Up After High-Intensity Care for Substance Use Disorder (fui)			
Follow-Up After High-Intensity Care for Substance Use Disorder - 30 days (Total)	NR	40.00%*	NA
Follow-Up After High-Intensity Care for Substance Use Disorder - 7 Days (Total)	NR	25.00%*	NA

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (fua)			
Total - 30-Day Follow-Up	0.00%*	20.69%	NA
Total - 7-Day Follow-Up	0.00%*	8.62%	NA
Pharmacotherapy for Opioid Use Disorder (POD)			
Pharmacotherapy for Opioid Use Disorder (Total)	NR	41.38%	NA
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	100%*	76.60%	NA
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	NR	75.00%*	NA
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (smc)	NR	NR	NA
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	NR	66.67%*	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)			
Blood glucose testing - Total	NR	27.27%*	NA
Cholesterol Testing - Total	NR	18.18%*	NA
Blood glucose and Cholesterol Testing - Total	NR	18.18%*	NA
Effectiveness of Care: Overuse/Appropriateness			
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	NR	0.00%*	NA
Appropriate Treatment for Children With URI (uri)			
Total	NR	91.79%	NA
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)			
Total	NR	55.32%	NA
Use of Imaging Studies for Low Back Pain (lbp)	NR	70.37%	NA
Use of Opioids at High Dosage (hdo)	NR	1.67%	NA
Use of Opioids From Multiple Providers (uop)			
Multiple Prescribers	NR	35.23%	NA
Multiple Pharmacies	NR	0.00%	NA
Multiple Prescribers and Multiple Pharmacies	NR	0.00%	NA
Risk of Continued Opioid Use (cou)			
Total - >=15 Days covered	NR	9.15%	NA
Total - >=31 Days covered	NR	5.63%	NA
Access/Availability of Care			
Adults' Access to Preventive/Ambulatory Health Services (aap)			
Total	91.67%*	69.08%	NA
Initiation and Engagement of AOD Dependence Treatment (iet)			
Initiation of AOD Treatment: Total	NR	41.98%	NA
Engagement of AOD Treatment: Total	NR	11.11%	NA
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	100%*	92.70%	NA

Measure/Data Element	Measure Year 2021	Measure Year 2022	Percentage Point Difference
Postpartum Care	0.00%*	72.06%	NA
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)			
Total	NR	33.33%	NA
Utilization			
Well-Child Visits in the First 30 Months of Life (W30)			
Well-Child Visits in the First 30 Months of Life (First 15 Months)	NR	8.45%	NA
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	NR	41.67%*	NA
Child and Adolescent Well-Care Visits (WCV)			
Child and Adolescent Well-Care Visits (Total)	50.00%*	28.70%	NA

*Note: NR = not reported; * denominator less than thirty (30); NA = not able to be computed due to non-reported rates or unreliable rates with denominators of less than 30.*

Performance Improvement Project Validation

42 CFR §438.330 (d) and §457.1240 (b)

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

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

For this review, Humana submitted two PIPs. Topics for those PIPs included the Human Papillomavirus Vaccine (HPV) and the Prenatal and Postpartum PIP. Both PIPs scored in the "High Confidence in Reported Results" range as noted in the tables that follow. A summary of each PIP's status and the interventions is also included.

Table 26: Human Papillomavirus Vaccine PIP

Human Papillomavirus Vaccine (HPV)	
The HPV vaccine PIP is aimed at increasing HPV vaccines among 9–13-year-olds. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the human papillomavirus (HPV) vaccines. The goal rate for this PIP is 36.5%. Measure Year (MY) 2021 rate was 1.82% which improved to 3.85% for MY 2022 for the interim rate, with a final rate of 11.5%. This rate includes medical record, supplemental, and administrative data.	
Previous Validation Score	Current Validation Score
79/79=100% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	
• HEDIS metric monitoring dashboard to include data monitoring and tracking towards goals. • Clinical dashboard with HEDIS alerts to prompt Case Management staff to educate members on missing preventative services, including vaccines. • Targeted outreach campaigns specific to EPSDT program offerings. • Well child visit text campaign to support well-child visits with an effort to increase chances of positive provider-member relationship. • Member and Provider newsletters educating providers on HPV vaccine uptake importance. • Member Incentives. • Provider Newsletter education related to same day, same way campaign.	

Table 27: Prenatal and Postpartum PIP

Prenatal and Postpartum (PPC)	
The aim for the Prenatal and Postpartum PIP is to increase the rate of eligible women receiving timely prenatal and postpartum care. The purpose of this project is to align with state efforts of increasing postpartum compliance in South Carolina by 15% by 2026. There were low denominators for the baseline rates for MY 2021, with a rate of 100% for prenatal care (only 3 members included in the rate) and 0% for postpartum care (3 members in the rate). For MY 2022 interim rates, the results showed 84.49% for prenatal care (goal is 85.4%) and 57.59% (goal is 77.37%) for postpartum care. The final HEDIS rate is noted, however, as 92.7% for prenatal care, and 72.06% for postpartum care. The final MY 2022 rates show that prenatal care is above the goal, and the final rate for postpartum is below the goal but improving.	
Previous Validation Score	Current Validation Score
73/74=99% High Confidence in Reported Results	80/80=100% High Confidence in Reported Results
Interventions	

Prenatal and Postpartum (PPC)
• Implemented Case Management staffing structure to include a bi-lingual prenatal nurse and reminders. • Data monitoring through Cotiviti at a monthly cadence. • Targeted outreach campaigns specific to Humana Beginnings program offerings. • Provider newsletter educating providers on 12-month postpartum extended coverage. • Value Added Benefits for pregnant members that included car seats and cribs.

Details of the validation of the PMs and PIPs can be found in the Constellation Quality Health *EQR Validation Worksheets, Attachment 3*.

Humana met 75% of the standards in the Quality Improvement section for this EQR. *Figure 6: Quality Improvement Findings* provides a comparations of the scores from the 2023 EQR to the 2024 EQR.

Figure 6: Quality Improvement Findings

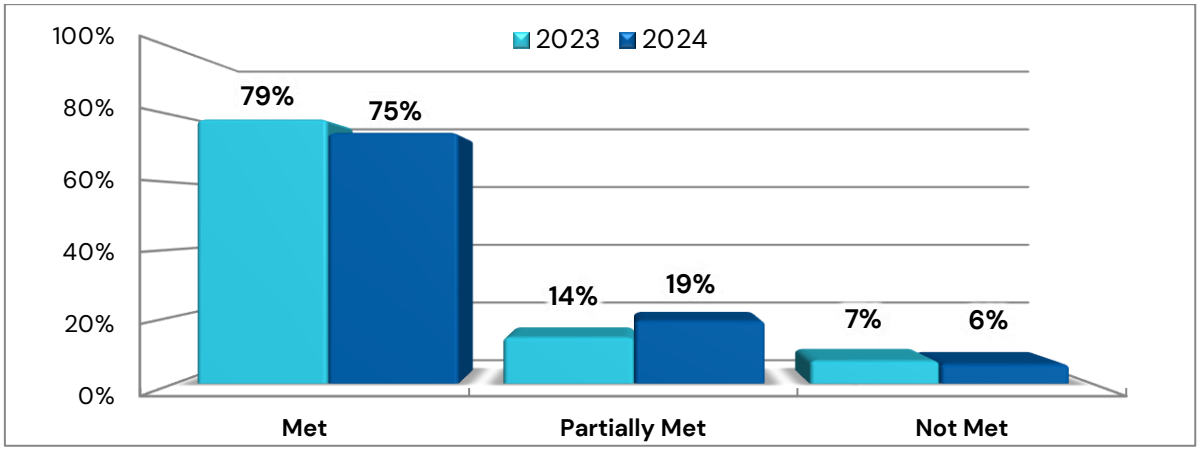


Table 28: Quality Improvement Comparative Data

Section	Standard	2023 Review	2024 Review
The Quality Improvement (QI) Program	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	Partially Met	Met
The Quality Improvement (QI) Program	An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Partially Met

Section	Standard	2023 Review	2024 Review
Quality Improvement Committee	Minutes are maintained that document proceedings of the QI Committee	Met	Partially Met

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

Table 29: Quality Improvement Strengths

Strengths	Quality	Timeliness	Access to Care
Humana shares results of provider performance with the Stars Quality Report and the Primary Care Provider Recognition Program Report.	✓		
Plan uses certified software for HEDIS calculations.	✓		
Both PIPs scored in the High Confidence range	✓		

Table 30: Quality Improvement Weaknesses, Recommendations, and Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Humana's website did not include any Humana specific performance measures.	*Recommendation: Include results of select HEDIS measures and CAHPS results on Humana's website.*	✓		
The following errors were identified in the 2022 and 2023 work plans: • The Nurse Advice Line activity (line 14 of the 2022 Work Plan) indicated a report for this activity would be submitted to the Quality Assurance Committee. There was no documentation in the committee minutes that this report was provided. • The Quality Assurance Committee was incorrectly referred to as the Quality Assessment Committee and the Quality Assessment and Performance Improvement Committee in the 2022 and 2023 work plans. • In the 2023 work plan, the goal for the NICU activity states, "Track and trend average length of stay." However, the average length of stay is not being reported. The number of NICU admissions	*Quality Improvement Project: Correct the errors noted in the QI work plans.*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
and the follow-up provided by Case Management was being reported. • The Performance Improvement Projects, line 26 of the 2023 work plan is missing the HPV project.				
The lack of a variety of participating network providers on the Quality Assurance Committee as required by the *SCDHHS Contract, Section 15.3.1.2* continues to be an issue for Humana.	*Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.*	✓		
The QAC meeting minutes did not reflect the appointed representative for voting members absent during the meetings. No documentation noted when minutes were changed or amended	*Quality Improvement Plan: Document in the QAC meeting minutes who has been appointed as the representative for voting members absent during the meetings.* *Develop a process for how errors or changes in the committee minutes should be documented and reported to the committee.*	✓		
The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation was missing data or results and contained goals that were incorrect. There were issues identified during the previous EQR and not corrected.	*Quality Improvement Plan: Correct the errors noted in the 2022 QI Program Evaluation and include a summary of the Delegation Oversight activities.*	✓		

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					Humana's Quality Improvement (QI) Program's focus is to monitor, evaluate, and facilitate improvement in the quality of health care services provided to members. The 2023 Quality Assessment and Performance Improvement Program Description describes the QI Program Humana has implemented to help achieve the goals that are outlined in the document. During the previous EQR (2023), Constellation Quality Health found the QI Program Description lacked information regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships). Humana addressed this deficiency and added a section in the Program Description and included a staffing structure, responsibilities, and resources. Members and providers are informed of the QI Program via Humana's website, the Member Handbook, and the Provider Manual. Humana's website states "We want you to feel confident that you made the right choice in your plan. View the HEDIS State of Health Care Quality Report:" and a link was provided for the HEDIS State of Health

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Care Quality Report on the NCQA website. However, this report was a summary report of performance measure results for commercial, Medicare and Medicaid health plans and is not health plan specific. *Recommendation: Include results of select HEDIS measures and CAHPS results on Humana's website.*
2. The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems.	X					The QI Program Description includes measuring or monitoring over and underutilization to identify any potential problems or issues.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).		X				Humana develops a work plan annually that includes measurable goals and objectives based on the previous year's annual evaluation. The 2022 and 2023 QI Work Plans were provided. The work plans included the quality improvement activities, the goals and objectives for each activity, the responsible party, and the expected completion date. The following errors were identified: • The Nurse Advice Line activity (line 14 of the 2022 workplan) indicated a report for this activity would be submitted to the Quality Assurance Committee. There was no documentation in the committee minutes that this report was provided. • The Quality Assurance Committee was incorrectly referred to as the Quality Assessment

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Committee and the Quality Assessment and Performance Improvement Committee in the 2022 and 2023 work plans. • In the 2023 work plan, the goal for the NICU activity states, "Track and trend average length of stay." However, the average length of stay is not being reported. The number of NICU admissions and the follow-up provided by Case Management was being reported. • The Performance Improvement Projects, line 26 of the 2023 work plan, is missing the HPV project. *Quality Improvement Project: Correct the errors noted in the QI work plans.*
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					The Quality Assurance Committee (QAC) is the local committee responsible for providing operational oversight of the QI Program. The 2023 Quality Assurance Committee Charter provided an overview of the committee's purpose, membership, responsibilities, meeting requirements, and reporting.
2. The composition of the QI Committee reflects the membership required by the contract.			X			The Committee Charter includes information about voting and non-voting members of the committee. This committee is chaired by the Chief Medical Officer and co-chaired by the Quality Improvement Lead. Other members of the committee include directors and representatives from the health plan's management staff. The *SCDHHS Contract, Section 15.3.1.2* requires a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						variety of participating network providers to be included as members of the QAC. The committee meeting minutes demonstrated Humana had recruited two network providers, a pediatrician and an OB/GYN provider. The pediatrician attended the meetings held in 2023 and resigned from the committee in January 2024. The OB/GYN physician only attended one meeting (May 2023). During onsite discussion, Humana indicated that a primary care physician had been recruited and will be added to the committee in May 2024. Additional copies of the committee meeting minutes were submitted following the onsite. This additional information did not address the lack of a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.* This was an issue identified during the previous EQR and not corrected. *Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.*
3. The QI Committee meets at regular quarterly intervals.	X					The Quality Assessment Committee meets at least quarterly.
4. Minutes are maintained that document proceedings of the QI Committee.		X				Minutes are documented for each meeting and presented to the committee for review and approval at the next scheduled meeting. The QAC 2023 Charter indicates a quorum of fifty percent of the voting members plus one must be present for committee action, and voting members are expected to attend each meeting or appoint a

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						representative in their absence. The committee meeting minutes did not reflect the appointed representative for voting members absent during the meetings. Also, the August 2023 meeting minutes indicated the Committee Chair was absent. However, the minutes reflected the meeting was called to order by the Committee Chair. After the onsite, Humana submitted another copy of the QAC meeting minutes for meetings held in 2023. It was noted that for the August 2023 meeting, the voting members' attendance had changed. The Compliance Lead, the Clinical Pharmacy Director, and the OB/GYN external physicians were marked as present in the committee meeting minutes submitted after the onsite. These voting members were noted as absent in the meeting minutes submitted with the desk materials. Also, an external physician (pediatrician) was noted as absent in the meeting minutes submitted after the onsite. There was no documentation indicating why the attendance was changed and the minutes amended. *Quality Improvement Plan: Document in the QAC meeting minutes who has been appointed as the representative for voting members absent during the meetings. Develop a process for how errors or changes in the committee minutes should be documented and reported to the committee.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
IV C. Performance Measures *42 CFR §438.330 (c) and §457.1240 (b)*						
1. Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	X					Humana uses certified software (Cotiviti) for calculation of HEDIS rates. The rates were audited by the Dunwood Technology Services Group. Due to all rates having at least one measurement year of unreliable rates with denominators less than 30, percentage point differences are not reported. Constellation Quality Health found the performance measures met the validation requirements.
IV D. Quality Improvement Projects *42 CFR §438.330 (d) and §457.1240 (b)*						
1. Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population.	X					Two performance improvement projects were submitted for validation. Topics included the HPV Vaccine and the Prenatal and Postpartum Care PIP.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					The HVP Vaccine PIP is aimed at increasing the HPV Vaccines among 9 – 13-year-olds. The Prenatal and Postpartum Care PIP is aimed at ensuring eligible women receive timely prenatal and postpartum Care. Both PIPS received scores within the "High Confidence in Reported Results Range" and met all the validation requirements.
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Humana shares results of provider performance with the Stars Quality Report and the Primary Care Provider Recognition Program Report.
3. The MCO tracks provider compliance with						
3.1 Administering required immunizations;	X					
3.2 performing EPSDTs/Well Child Visits.	X					Policy SC.QLT.005, Early and Periodic Screening, Diagnostic and Treatment Program outlines Humana's approach to improving visit and screening rates of EPSDT services. EPSDT services and immunizations are tracked on a quarterly basis and monitored through population health dashboards as well as Utilization Management reporting. Performance metrics are presented and reviewed by the Quality Assurance Committee on an annual basis.
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				At least annually, Humana assesses the effectiveness of their quality program. The 2022 Humana Healthy Horizons in South Carolina Quality Improvement Evaluation provided the annual analysis of Humana's QI program with barriers, interventions, and conclusions or recommendations for each activity. Constellation

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

						Quality Health found the previously identified issues were not corrected in the evaluation received for this EQR. There were issues with missing data or results and incorrect goals being measured. Those included:
						• The Delegation Oversight activity was not included in the evaluation.
						• Page 33, Section D, Monitoring and Improving Patient Safety indicates the goal for this activity is set at:
						  ○ 80% of cases are closed or sent to Peer Review Committee within 90 days
						  ○ 90% of cases are closed or sent to Peer Review Committee within 120 days
						However, the goal in the 2022 QI work plan for this activity is listed as 90% of the cases are closed or sent to the Peer Review Committee within 120 days, and 95% within 160 days.
						• The tables on pages 38 and 39 note there were no complaints, grievances, and appeals for 2022 related to access. However, the Grievance and Appeal section of the evaluation (page 47) noted several grievances in the second, third and fourth quarters of 2022 related to provider access issues.
						• Page 47 states there were no Behavioral Health grievances or appeals for 2022. However, under the Qualitative Analysis section, grievances related to behavioral health are noted in the second and third quarters of 2022.
						• The graph on page 86 was upside down.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Correct the errors noted in the 2022 QI Program Evaluation and include a summary of the Delegation Oversight activities.
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

E. Utilization Management

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

Humana's Utilization Management Program Description and various policies outline the scope, objective, and staff roles and responsibilities within the UM program for behavioral health and physical health services. Pharmaceutical services are also provided to the members, and the program's scope is provided in the Pharmacy Program Description and various policies.

In the previous EQR, Constellation Quality Health noted that the UM Program Description incorrectly referenced the "Quality Assessment Committee" as providing oversight of the UM Program and there were inconsistences in identifying the health plan's current pharmacy benefit manager. During this EQR, it is noted that Humana corrected the identified issue and the reflected the committee, Quality Assurance Committee provided oversight and pharmacy benefit manager as Humana Pharmacy Solutions. Please see Table 31 below for the specific issue, corrective actions, and Humana's response:

Table 31: Previous Utilization Management Procedure QIP Item

Standard	2023 EQR Findings	2024 EQR Findings
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:	Humana provided the Utilization Management (UM) Program Description 2023 for review. This Program Description outlines the staff responsibilities, scope, and objectives for physical and behavioral health services. Page five of the UM Program Description indicates the Quality Assessment Committee provides monitoring, oversight, and direction of the UM Program. During the onsite, staff indicated the committee responsible for oversight of the UM Program is the Quality Assurance Committee. This was identified in the 2022 UM Program Description during the 2022 EQR. CCME recommended Humana correct the UM Program Description; however, that change was not made in the 2023 UM Program Description. The Pharmacy Program is integrated into the UM Program. According to the 2023 Pharmacy Program Description, Humana Pharmacy Solutions is the pharmacy benefit	The issues identified during the previous EQR were corrected. Humana developed a policy to address identified the correct committee that provided UM Committee oversight within the UM Program Description and also provided the correct pharmacy benefit manager as Humana Pharmacy Solutions.

Standard	2023 EQR Findings	2024 EQR Findings
	manager. However, page 15 of the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager. *Quality Improvement Plan: Correct the deficiencies in the UM Program Description and remove the references to the Quality Assessment Committee. Also, verify the pharmacy benefit manager for SC and correct the UM Program Description, Pharmacy Program Description, and/or Humana's website.*	
Humana's Response: Humana has updated the UM Program Description by removing references to the Quality Assessment Committee. Humana also updated the pharmacy benefit manager, Humana Pharmacy Solutions.		

Humana's Chief Medical Officer, a senior level physician, provides oversight and management of the UM program, and responsibilities include committee participation, consultation, etc. The Behavioral Health Director is a senior licensed psychiatrist that provides support to the Chief Medical Officer and provides management of the behavioral health UM activities. The Pharmacy Director is a licensed pharmacist that oversees pharmacy services, and responsibilities entail formulary oversight, monitoring trends, peer-to-peer collaboration, etc.

Coverage and Authorization of Services

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

Initial clinical reviews are conducted by approved licensed clinicians for medical, behavioral health, and pharmacy authorization requests. The UM reviewers utilize approved clinical criteria such as Milliman Clinical Guidelines (MCG), Humana Coverage policies, American Society of Addiction (ASAM), etc. to evaluate medical necessity. During onsite discussion, Humana shared that the Clinical Intake Team provides support to the UM department by conducting non-clinical activities, such as data entry and routing service requests for review.

The UM determinations are based on the appropriateness of care and do not reward practitioners or others involved in the UM process for issuing coverage denials. Also, Humana conducts annual Inter-rater Reliability (IRR) testing to assess consistency in decision making for all staff who make determinations. Based upon the IRR results, the goal of 90% or higher was met with the average score of 98.3%.

Standard authorizations are processed within 14 calendar days and urgent requests are processed within three calendar days. Retrospective requests are processed within 30 calendar days.

Pharmacy prior authorization requests are processed within 24 hours and in emergent situations, a 72-hour emergency supply of medication is provided until a decision is rendered. In the previous EQR, Constellation Quality Health noted that the contractual requirement for this emergency medication supply was not outlined in the Pharmacy Program Description, Member Handbook, Provider Manual, or policies. During this EQR, it is noted that Humana corrected the identified issue and developed Policy SC.RX.022 to document the process for an emergency 72-hour supply of medication. Please see Table 32 below for the specific issue, corrective actions, and Humana's response:

Table 32: 2023 EQR Medical Necessity Determination Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
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*		
6. Pharmacy Requirements 6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	Processes for medication prior authorization requests are discussed in the Pharmacy Program Description, which mentions providers receive a determination notification within 24 hours of a request for prior authorization. The *SCDHHS Contract, Section 4.2.21.3.2,* requires the health plan to authorize a 72-hour emergency supply of medications to members in emergent situations until a decision is received. There was no mention of the process used to meet this requirement in the Pharmacy Program Description, the Member Handbook, Provider Manual, or in a policy. During onsite discussion, the health plan was able to describe the process when an emergency supply is needed; however, this process is not documented. *Quality Improvement Plan: Develop a policy and include in the Pharmacy Program Description the process followed to authorize a 72-hour supply of medications to the members in emergent situations, as required by the SCDHHS Contract, Section 4.2.21.3.2.*	The issues identified during the previous EQR were corrected. Humana developed a policy to address the process for an emergency 72-hour supply of medications according to contractual regulations.
Humana's Response: Humana has developed policy SC.RX.022 to document the process for an emergency 72-hour supply of medication.		

Also, during the previous EQR, Constellation Quality Health noted that there were two policies watermarked as draft and containing tracked changes. During this EQR, it is noted that Humana corrected the identified issue and developed Policy SC.CLI.010 – Evaluation of Preauthorization

List (PAL) Additions and Removals to outline the process. Please see *Table 33* below for the specific issue, corrective actions, and Humana's response:

Table 33: Guidelines In Making Utilization Management Decisions Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
1.3 guidelines / standards to be used in making utilization management decisions;	Per the UM Program Description, Utilization Management decisions are made using established UM criteria. Criteria are evaluated and approved on an annual basis. All review decisions are based on the information collected at the time of the request. Humana maintains a list of services that require prior authorization. Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 provide an overview of how these lists are established, maintained, and updated. During the 2022 EQR, CCME noted both policies contained basically the same information and were watermarked as "draft." No explanation was provided regarding the purpose of both policies. A recommendation was made to review both policies to determine which policy best defines the process Humana uses to manage the preauthorization list. For this EQR, Humana did not provide these policies with the desk materials. CCME questioned staff during the onsite and the staff indicated the policies were still active. Copies were provided. The copies provided were still labeled as draft and contained tracked changes. *Quality Improvement Plan: Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002, finalize the tracked changes, and remove the draft watermark.*	The issues identified during the previous EQR were corrected. Humana developed a policy to outline the preauthorization list process.
Humana's Response: Humana's Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 have been consolidated into one policy, SC.CLI.010 – Evaluation of Preauthorization List (PAL) Additions and Removals.		

Constellation Quality Health's review of a sample of approval files demonstrated use of appropriate criteria while considering relevant medical information. Also, appropriately trained reviewers made the UM decisions. In review of the UM Program Evaluation, Humana exceeded the target monthly goal of 95% for processing behavioral health and medical service authorization requests.

Constellation Quality Health's review of a sample of denial files demonstrated that adverse benefit determinations were promptly communicated to the provider and member. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, the sample adverse benefit determination letters and the adverse benefit determination letter templates incorrectly informed the member that a written appeal is required when an oral request is submitted.

Appeals

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

Humana outlines processes and instructions for filing and handling member appeals in Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, Policy SC.MCC.005, Member Grievances and Appeals, the Provider Manual, the Member Handbook, and on the website. These materials define appeal terminology and provide options for filing the member's request for standard and expedited appeals.

Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not indicate that a grievance can be filed if the filer disagrees with an extension of the appeal resolution timeframe. It was found that appeals are logged and categorized appropriately, monitored for trends, and reported quarterly as reflected in Quality Assurance Committee minutes.

A sample of appeal files was reviewed for this EQR. All were resolved timely and reviewed by appropriate clinical staff.

During the previous EQR, the issues identified in *Table 34* were found. Humana's responses to the Quality Improvement Plan are also reflected in the table. The review of the appeal files revealed the elements from the prior corrective action plan were addressed.

Table 34: 2023 EQR Appeal Deficiency

Standard	2023 EQR Findings	2024 EQR Findings
V C. Appeals		
2. The MCO applies the appeal policies and procedures as formulated.	Humana provided a sample of appeal files for review. The following issues were identified in the files: • The resolution notices for five files indicated the decision was made by a specialist in the Grievance and Appeal Department or by a medical director. However, the decisions were made by a consultant with the Network Medial Review Company.	Humana provided a sample of appeal files for review for the current EQR. The files demonstrated the appropriately credentialed reviewer, and language used in member written correspondence was at an appropriate reading.

Standard	2023 EQR Findings	2024 EQR Findings
	• The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. The resolution letters included references to medical literature and medical terminology such as "tardive dyskinesia," "neuroendocrine tumors," and "hypereosinophilic syndrome." These were the same issues identified during the 2022 EQR. Also, three expedited appeal requests were not resolved within the 72-hour timeframe. In two of the files, it appeared the physician reviewer used a KY administrative code and a KY fee schedule for making the determination. *Quality Improvement Plan: Develop a process for monitoring resolution notices to ensure the letters contain correct reviewer information and meet the SCDHHS 6th grade reading level requirement (SCDHHS Contract, Section 3.15.12 and 42 CFR § 438.10). Also, monitor timeliness for completing expedited appeals and remind reviewers that other state administrative codes and fee schedules should not be used for making determinations.*	
Humana's Response: Humana's grievance and appeal leadership has daily inventory meetings. Cases that are at risk of noncompliance are communicated to the associate and monitored. A root cause analysis is completed for cases out of compliance. Humana currently conducts letter auditing on a monthly basis to review readability. Staff are also provided the Government Programs Letter Readability Procedure guide to reference. In addition, Humana will retrain associates on letter writing in Q3 2023.		

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

An overview of the Care Management (CM) Program, including care management and care transitions processes, is found in the Care Management Program Description and various policies.

Members are identified for CM through various sources such as enrollment files, nurse advice line notifications, discharge planning, community organization referrals, provider referrals, or self-referrals. Additionally, during the onsite visit, Humana shared that they have implemented the Readmission Predictive Modeling System to aid in identifying potential members for care management. Referrals for case management services are accepted by fax, mail, email, or phone.

Based upon results of the Health Risk Assessment, members are provided care management activities that are appropriate to their identified risk level. The various risk levels include CM Low Risk, CM Moderate Risk, Intensive CM for High Risk Enrollees, and Complex CM. Specialized programs are also offered for chronic condition management and special health care needs.

Humana also provides an integrated care model for members who are identified as having both physical and behavioral health needs. Members are assigned a primary care manager based upon their most prevalent identified needs, and behavioral health team meetings and care management activities are provided to ensure that care is comprehensive.

Transition of care services are provided for members that are transitioning between health plans, new members, etc. Policy SC.CLI.002, Continuity of Care and Care Transitions, provides an overview of continuity of care for members entering the health plan, pregnant member, etc. However, this policy does not address continuity of care while a member is in the appeals process.

An annual review of the CM Program is conducted to assess member experience and identify any gaps in care. The results of the survey aid to develop population health management strategies, identify opportunities for improvement, and program development. During the onsite discussion, Humana reported difficulty in obtaining an adequate sample size to fully assess the effectiveness of the program and indicated they have developed strategies to increase the survey sample pool.

Review of a sample of CM files revealed care management activities were conducted as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources.

Figure 7 provides an overview of Humana's 2023 score compared to the score received in the 2024 EQR.

Figure 7: Utilization Management Findings

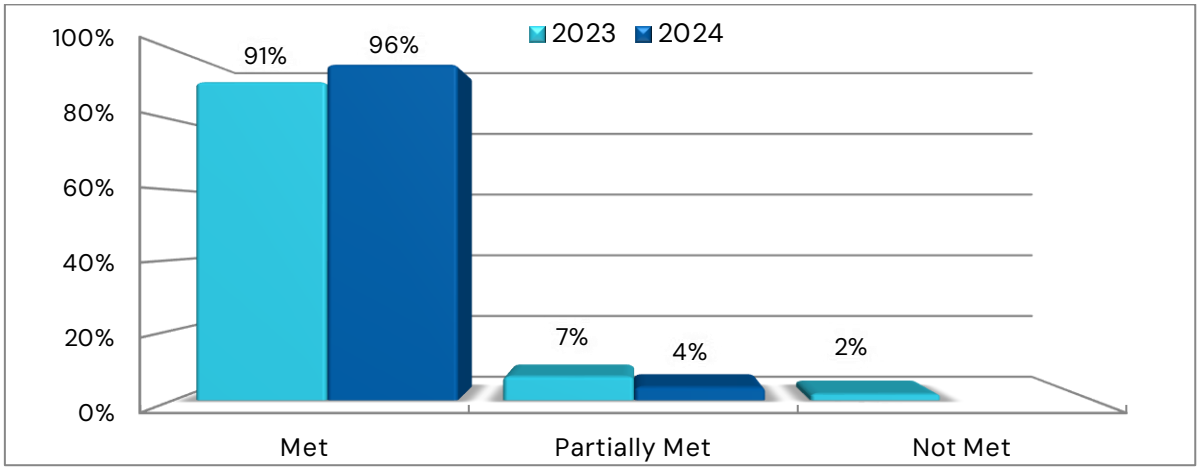


Table 35: Utilization Management Comparative Data

Section	Standard	2023 Review	2024 Review
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program	Partially Met	Met
Medical Necessity Determinations	If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Partially Met	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
Appeals	The MCO applies the appeal policies and procedures as formulated.	Partially Met	Met

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

Table 36: Utilization Management Strengths

Strengths	Quality	Timeliness	Access to Care
Humana exceeded the target monthly goal of 95% for processing behavioral health and medical service authorization requests.		✓	
Review of the sample approval files yielded that files were completed timely and completed by appropriate licensed professionals.		✓	
The IRR goal of 90% or higher for the Medical Directors and UM reviewers were met with the average score of 98.3%.	✓		
Of the appeals files reviewed for this EQR, all were addressed timely and were reviewed by the appropriately credentialed reviewer.		✓	
The Member Handbook, Appeals section, describes steps for a member to file an appeal, including instructions for submitting an oral appeal, obtaining forms for submitting an appeal in writing, and the online submission process.			✓
Appeal correspondence acknowledgement and resolution letters to members were clear with appropriate information needed specific to determination or next steps as applicable.	✓		

Table 37: Utilization Management Weaknesses, Recommendations and Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Adverse benefit determination letters in Humana's sample of denial files and the adverse benefit determination letter templates incorrectly informed the member that a written appeal is required when an oral request is submitted, and this is no longer a contractual requirement	*Quality Improvement Plan: Remove the requirement that a written appeal request must be submitted following an oral request for an appeal in the adverse benefit determination notices.*			✓
Policy SC.CLI.002 Continuity of Care and Care Transitions provides an overview of when continuity of care is provided for the members entering the health plan, pregnant, etc. However, this policy does not address continuity of care while a member is in the appeals process.	*Recommendation: Consider adding in policy the member's ability to receive continual transition of care while in the appeals process.*	✓		
Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not indicate that a grievance can be filed if the filer disagrees with the request for an extension of 14 days.	*Quality Improvement Plan: Correct policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template to indicate that a grievance can be filed if the filer disagrees with the extension request as reflected in Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*	✓		

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					Humana's Utilization Management Program Description and various policies outline the scope, objective, and staff roles and responsibilities within the UM program for physician and behavioral health services. Pharmaceutical services are also provided to the members and the program's scope is provided in the Pharmacy Program Description and various policies.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					Humana's UM Program Description provides an overview of the health plan's program and states medical necessity criteria include Milliman Clinical Guidelines (MCG), Humana Coverage policies, American Society of Addiction (ASAM), etc. for determining medical necessity.
1.2 lines of responsibility and accountability;	X					The Chief Medical Officer provides Oversight of the UM Program. Initial clinical reviews are conducted by licensed clinicians for medical authorization requests, licensed mental health professionals for behavioral health authorization requests, and licensed pharmacists for pharmacy authorization requests. The Clinical Intake Team provides support to the UM

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						department by conducting non-clinical activities such as data entry and routing service requests for review.
1.3 guidelines / standards to be used in making utilization management decisions;	X					
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					Policy SC.CLI.005 Timeliness: UM Determinations and Notifications describes that standard authorizations are processed within 14 calendar days and urgent requests are processed within 3 calendar days. Retrospective requests are processed within 30 calendar days and pharmacy requests are processed within 24 hours.
1.5 consideration of new technology;	X					
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					Policy SC.CLI.1008, UM Program Description, states that everyone associated with the health plan, including the Board of Directors, committee members, and consultants, sign a Conflict of Interest Statement at the time of hire and annually during ethics training. Also, Humana states that UM decisions are based on the appropriateness of care and do not reward practitioners or others involved in the UM process for issuing coverage denials. This information is communicated to all plan associates, members, and providers.
1.7 the mechanism to provide for a preferred provider program.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					Humana's Chief Medical Officer provides overall oversight and management of the UM Program, and responsibilities include committee participation, consultation, and evaluation activities of the UM Program. The Behavioral Health Medical Director is a licensed psychiatrist that provides support to the Chief Medical Officer and provides management of the behavioral health UM activities. The Pharmacy Director is a licensed pharmacist that oversees pharmacy services, and responsibilities entail formulary oversight, monitoring trends, peer-to-peer collaboration, etc.
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					
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					
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Constellation Quality Health's review of a sample of approval files demonstrated use of appropriate criteria and consideration of relevant medical information.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Humana conducts annual Inter-rater Reliability (IRR) testing to assess consistency in decision making for all staff who make clinical determinations. The testing assesses criteria areas such as Milliman Care Guidelines (MCG), Provider Manual Criteria, ASAM, and behavioral health questions. Based upon the IRR results, the goal of 90% or higher was met with the average score of 98.3%.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					Processes for medication prior authorization requests, Pharmacy Lock-in Program, and Preferred Drug Lists are outlined in the Pharmacy Program Description and various policies. Pharmacy prior authorization requests are processed within 24 hours and in emergent situations, a 72-hour emergency supply of medications is provided to members until a decision is rendered. Also, members have a monthly allowance to receive over the counter medications.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.	X					
7. Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations.	X					
8. Utilization management standards/criteria are available to providers.	X					
9. Utilization management decisions are made by appropriately trained reviewers.	X					Constellation Quality Health's review of a sample of approval files reflected that appropriately trained reviewers made the UM decisions.
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of a sample of approval files confirmed that determinations were made in a timely manner according to contractual requirements. As noted in the UM Program Evaluation, Humana exceeded the target monthly goal of 95% for processing behavioral health and medical service authorization requests.
11. Denials						
11.1 A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services.	X					
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					Review of a sample of denial files reflected that appropriately licensed physicians made the adverse benefit determinations.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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				Constellation Quality Health's review of a sample of adverse benefit determinations demonstrated that the decisions were promptly communicated to the provider and member. Additionally, the reason for the adverse benefit determination and the right to request a State Fair Hearing were indicated. However, the sample of adverse benefit determination letters and the adverse benefit determination letter templates incorrectly informed the member that a written appeal is required when an oral request is submitted. *Quality Improvement Plan: Remove the requirement that a written appeal request must be submitted following an oral request for an appeal in the adverse benefit determination notices.*
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						
1. The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including:		X				Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, and Policy SC.MCC.005, Member Grievances and Appeals, describe processes for responding to appeals. Appeals information is included in the Member Handbook and Provider Manual. However, Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template (Extension Section) do not indicate that a grievance can be

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						filed if the member disagrees with an extension of the appeal resolution timeframe. *Quality Improvement Plan: Correct Policy SC.MCC.005, Member Grievances and Appeals, and the Appeals Acknowledgment Letter Template to indicate that a grievance can be filed if the filer disagrees with an extension of the appeal resolution timeframe. as required by the SCDHHS Contract, Section 9.1.6.1.4 and 9.1.6.1.5.*
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					The definition of an appeal is consistently documented in the Member Handbook and Provider Manual as an "…enrollee's expression of dissatisfaction with a decision made by Humana regarding an authorization or a claim."
1.2 The procedure for filing an appeal;	X					The Member Handbook provides instruction for filing an appeal, including verbal, written, and online submissions.
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					Expedited appeals are completed within 72 hours as outlined in Policy SC.GAA.01, SC Medicaid Grievance and Appeal Policy, the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Member Handbook, Provider Manual, and the health plan's website.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					Appeal resolution timeframes are appropriately documented in Policy SC.MCC.005, Member Grievances and Appeals, Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy, the Provider Manual, and the Member Handbook.
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					Of the appeals files reviewed for this EQR, all were addressed timely and were reviewed by the appropriate staff.
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					Appeals are logged and categorized appropriately, monitored for trends, and reported quarterly to the Quality Assurance Committee.
4. Appeals are managed in accordance with the MCO confidentiality policies and procedures.	X					
V. D Care Management and Coordination *42 CFR § 208, 42 CFR § 457.1230 (c)*						
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					An overview of the Care Management (CM) Program, including care management and care transitions processes, is found in the Care Management Program Description, Policy SC.CLI.002, Continuity of Care and Care

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Transitions, and Policy SC.CLI.003, Core Benefits and Services.
2. The MCO has processes to identify members who may benefit from care management.	X					Referrals for case management services are accepted by fax, mail, email, or phone. Members are identified for CM services through various sources such as enrollment files, nurse advice line notifications, discharge planning, community organization referrals, provider referrals, and self-referrals. Additionally, during the onsite visit, Humana shared that they have implemented the Readmission Predictive Modeling System to aid in identifying potential members for care management.
3. The MCO provides care management activities based on the member's risk stratification.	X					Based upon results of the Health Risk Assessment, members are provided care management activities appropriate to their risk level. The various risk levels include: • CM Low Risk – focuses on prevention and wellness for members. • CM Moderate Risk – for members that have at least one or more conditions that require a moderate level of management. • Intensive CM for High Risk Enrollees – for members with a high acuity level that require intensive support. • Complex CM – for members with multiple co-occurring conditions requiring intensive management.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Specialized programs are also offered for special population members such as chronic conditions management, enrollees with special health care needs, and members in foster care.
4. The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members.	X					
5. The MCO conducts required care management activities for members receiving behavioral health services.	X					Humana's CM Program Description provides an overview of the integrated model for members with both physical health and behavioral health needs. Members are assigned a primary care manager based upon their prevalent needs. However, behavioral health team meetings and care management activities are provided to ensure that care is comprehensive.
6. Care Transitions activities include all contractually required components.						
6.1. The MCO has developed and implemented policies and procedures that address transition of care.	X					Policy SC.CLI.002, Continuity of Care and Care Transitions, provides an overview of continuity of care services provided for members entering the health plan, pregnant members, etc. However, this policy did not address continuity of care while a member is in the appeals process. *Recommendation: Consider adding in a policy the member's ability to receive continual transition of care while in the appeals process.*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
6.2. The MCO has a designated Transition Coordinator who meets contract requirements.	X					
7. The MCO measures care management/care coordination performance and member satisfaction and has processes to improve performance when necessary.	X					An annual review of the CM Program is conducted to assess member experience and identify any gaps in care. The results of the survey aid in developing population health management strategies, identifying opportunities for improvement, and in program development. During onsite discussion, Humana shared difficulty in obtaining an adequate sample size to fully assess the effectiveness of the program and that they have developed strategies to increase the survey sample pool.
8. Care management and coordination activities are conducted as required.	X					Review of a sample of care management files showed that care management activities were conducted as required, including assessments, treatment planning, follow up, and linkage to appropriate community resources.
V E. Evaluation of Over/ Underutilization						
1. The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract.	X					
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

F. Delegation

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

Humana delegates to subcontractors and/or vendors to perform health plan activities, including some utilization management services, translation services, non-emergency transportation, credentialing, health risk assessments, nurse advice line, health coaching, and other services. For this EQR, Humana reported 14 subcontractors and/or vendors. *Table 38: Delegated Entities and Services* provides an overview of the delegates and the services provided.

Table 38: Delegated Entities and Services

Delegated Entities	Delegated Functions	Monitoring Frequency
ANMED Health	Credentialing	Annual Audit, Semi-Annual Reporting
Block Vision, dba Superior Vision Benefit Management	Vision Network Management, Claims Processing, Credentialing	Annual Audit, Semi-Annual and Monthly Reporting
Censeo Health, dba Signify Health	Credentialing, Health Risk Assessments	Annual Audit, Semi-Annual Reporting
Focus Health, dba Focus Behavioral Health	Behavioral Health Utilization Management, Appeals	Annual Audit, Semi-Annual and Monthly Reporting
Hanger Prosthetics & Orthotics	Credentialing	Annual Audit, Semi-Annual Reporting
HCN Physicians and the subsidiaries of Tenet Healthcare	Credentialing	Annual Audit, Semi-Annual Reporting
Medical University Hospital Authority/MUSC Medical Center	Credentialing	Annual Audit, Semi-Annual Reporting
Modivcare Solutions	Non-emergent transportation services, Claims Processing	Annual Audit, Monthly Reporting
Network Medical Review Company	Utilization Management, Appeals	Annual Audit, Quarterly Audits, Quarterly Reporting
Prisma Health	Credentialing	Annual Audit, Semi-Annual Reporting
Self Regional Healthcare	Credentialing	Annual Audit, Semi-Annual Reporting
South Carolina Department of Mental Health	Credentialing	Annual Audit, Semi-Annual Reporting

Delegated Entities	Delegated Functions	Monitoring Frequency
St. Francis Physician Services	Credentialing	Annual Audit, Semi-Annual Reporting
United Physicians	Credentialing	Annual Audit, Semi-Annual Reporting

Humana's 2023 Subcontractor and Oversight Monitoring Plan and Policy SC.DCO.001, Delegation Policy, describes the oversight process for any activity or function that has been delegated to another entity. This process includes a pre-delegation audit conducted prior to any function being delegated. Annual audits are conducted to evaluate all delegates' continued ability to meet the contract requirements and performance standards. Policy SC.DCO.001 indicates that delegates are required to request approval from Humana to sub-delegate any portion of the delegated functions or activities. However, this policy does not include the requirement to notify SCDHHS of any further delegation by a subcontractor (*SCDHHS Contract, Section 2.5.11*).

Humana provided copies of the annual delegation oversight monitoring. The following issues were identified in the audit tools:

- The element regarding the CLIA was marked as not applicable for six of the delegates during the file review.
- For three of the delegates, the nurse practitioner agreement was not checked during the file review. This element was marked as not applicable.
- Hospital admitting privileges were not checked during the file review for one delegate.

Following the onsite visit, Humana responded to these deficiencies and acknowledged these elements were not scored appropriately during the annual audits.

Humana met 50% of the requirements in the Delegation Section. Issues with the Delegation policy and the deficiencies noted in the annual audit tools resulted in a "Partially Met" score as noted in the figure and table that follows.

Figure 8: Delegation Findings

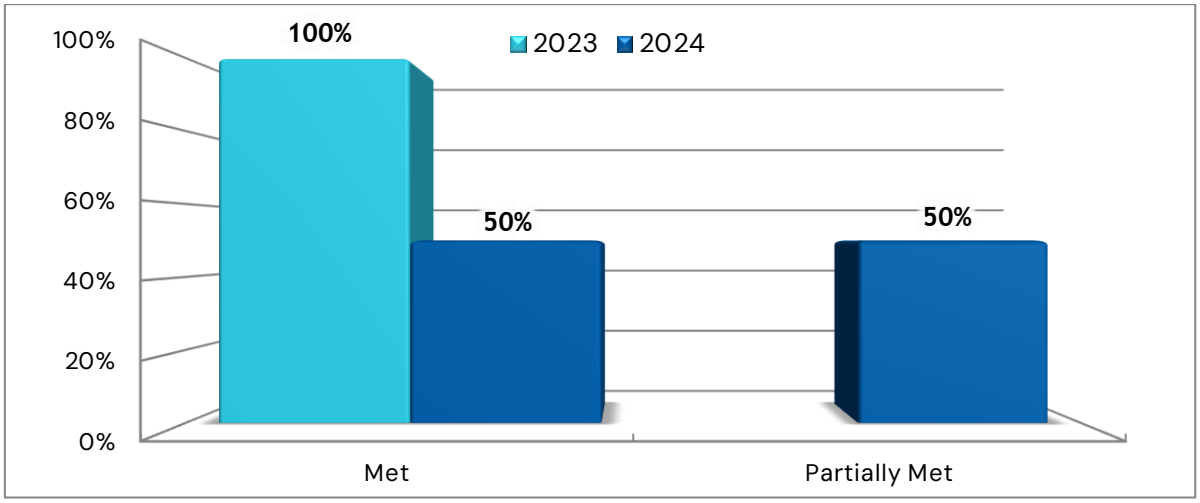


Table 39: Delegation Comparative Data

Section	Standard	2023 Review	2024 Review
Delegation	The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	Met	Partially Met

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

Table 40: Delegation Strengths

Strengths	Quality	Timeliness	Access to Care
Humana measures compliance and performance of all delegated vendors.	✓		

Table 41: Delegation Weaknesses, Recommendations, and Quality Improvement Plans

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Policy SC.DCO.001 includes the specific requirements for sub-delegation.	*Quality Improvement Plan: Include the SCDHHS requirement to notify*	✓		

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Delegates are required to request approval from Humana to sub-delegate any portion of the delegated functions or activities. However, this policy does not include the requirement to notify SCDHHS of any further delegation by a subcontractor (*SCDHHS Contract, Section 2.5.11*).	*SCDHHS of any further delegation by a subcontractor. Also ensure this requirement is included in each delegate's contract.*			
Humana provided copies of the annual delegation oversight monitoring. The following issues were identified in the audit tools: • The element regarding the CLIA was marked as not applicable for six of the delegates during the file review. • For three of the delegates, the nurse practitioner agreement was not checked during the file review. This element was marked as not applicable. • Hospital admitting privileges were not checked during the file review for one delegate.	*Quality Improvement Plan: Re-educate staff conducting the annual oversight audits regarding the credentialing and recredentialing requirements that should be checked during the file review.*	✓		

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					
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				Humana's 2023 Subcontractor and Oversight Monitoring Plan and policy SC.DCO.001, Delegation Policy describes the oversight process for any activity or function that has been delegated to another entity. This process includes a pre-delegation audit conducted prior to any function being delegated. Annual audits are conducted to evaluate all delegates' continued ability to meet the contract requirements and performance standards. Policy SC.DCO.001 includes the specific requirements for sub-delegation. Delegates are required to request approval from Humana to sub-delegate any portion of the delegated functions or activities. However, this policy does not include the requirement to notify SCDHHS of any further delegation by a subcontractor (*SCDHHS Contract, Section 2.5.11*).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Humana provided copies of the annual delegation oversight monitoring. The following issues were identified in the audit tools: • The element regarding the CLIA was marked as not applicable for six of the delegates during the file review. • For three of the delegates, the nurse practitioner agreement was not checked during the file review. This element was marked as not applicable. • Hospital admitting privileges were not checked during the file review for one delegate. Following the onsite, Humana responded to these deficiencies and acknowledged the elements were not scored appropriately during the annual audits. *Quality Improvement Plan: Include the SCDHHS requirement to notify SCDHHS of any further delegation by a subcontractor. Also, ensure this requirement is included in each delegate's contract.* *Re-educate staff conducting the annual oversight audits regarding the credentialing and recredentialing requirements that should be checked during the file review.*

G. Mental Health Parity

The Mental Health Parity and Addiction Equity Act (Federal Parity Act) of 2008 requires health plans to cover behavioral health/substance use disorder and medical/surgical benefits equally. Constellation Quality Health is required to conduct a Mental Health Parity assessment to determine if Humana met the Mental Health Parity requirements outlined in the Federal Parity Act. This assessment is conducted as a two-step process. Step one involves assessing the quantitative treatment limitations (QTLs), which are limits on the scope or duration of benefits that are represented numerically, such as day limits or visit limits. The second step assesses the non-quantitative treatment limitations (NQTLs) such as medical management standards, provider network admission standards and reimbursement rates, policies, and other limits on the scope or duration of benefits.

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

Constellation Quality Health reviewed Humana's supporting documentation to assess both elements of NQTL Parity: comparability and stringency. Compliance with these two factors depends on a parity of process, policy, and practice.

Review Criteria – Humana uses MCG as their medical and behavioral health criteria. ASAM is used for substance use disorders. Humana does have internally developed criteria as well, but does not use them, per response to questioning during the onsite.

UM Reviews: Humana has delegated their mental health adverse determinations and appeals to FOCUS. Monthly Joint Operational Committee meetings have been established for vendor oversight. They continue to work to improve communications and streamline handoff processes, which are complicated by system incompatibility between Humana and FOCUS.

Appeals and Denials – Medical necessity denial rates for medical/surgical and behavioral health/substance use are comparable. Administrative denials are not being used currently, as Humana is still building their provider network.

Mental health/substance use disorder (MH/SUD) appeal overturn rates are lover for mental health benefits (both inpatient and outpatient) while pharmacy overturn rates are equal, as demonstrated in *Table 42: Appeal Overturn Rates*. This indicates denial determinations are very carefully made and appropriate for mental health services.

Table 42: Appeal Overturn Rates

Service	Medical Non-Mental Health Appeal Overturn Rate	Mental Health Appeal Overturn Rate
Inpatient	66.67%	33.33%

Service	Medical Non-Mental Health Appeal Overturn Rate	Mental Health Appeal Overturn Rate
Outpatient	45.71%	0.00%
Emergency	N/A	N/A
Prescription Drug	50%	50%

By comparing overturn rates for medical appeals and MH/SUD appeals, Constellation Quality Health can make an inference about stringency. If the appeal overturn rates are higher for MH/SUD than for medical benefits, it could mean that criteria are being applied more stringently. Administrative denials could indicate a discrepancy in comparability while medical necessity could indicate a discrepancy in stringency.

Provider Network: As a new health plan, Humana is still building their provider network. The network adequacy standards match between medical/surgical and MH/SUD, and the network gaps are similar between the two benefits. Humana's policy at this time is to not deny administratively based upon contracted status. Humana has launched a Network Adequacy Workgroup to address gaps in access to care, reflected in the low Experience of Care and Health Outcomes (ECHO) Survey results for the "Getting Treatment Quickly" composite.

The goal for the behavioral health network is a minimum of 90% of Humana members will have access to one network practitioner and provider facility within the specified mileage for their area.

Credentialing follows all State and Federal Regulatory requirements and NCQA guidance for both M/S and MH/SUD providers and practitioners.

Case Management: When looking at subpopulations, behavioral health is the most prevalent chronic condition. Members are stratified into five levels of severity and can participate in the Case Management Program. Humana has done a thorough job of assessing their membership mix by diagnosis, region, and acuity.

Humana has the tools, plans, and interventions to support the goal of parity. The NQTL assessment found the mental health services comply with parity requirements of comparability and stringency.

Mental Health Parity Quantitative Treatment Limitations (QTL) Assessment

Two templates were provided to Humana to complete for the mental health parity assessment. The templates allowed the plan to enter information based on copay, session limits, day limits, etc. This information was used to determine if financial requirements and QTLs that apply to mental health and substance use disorder benefits were no more restrictive than the predominant financial requirements and treatment limitations that apply to substantially all medical/surgical

benefits. There are two steps required to conduct this review: First, Constellation Quality Health determined if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits. For step two, the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject. *Table 43: Mental Health Parity Quantitative Treatment Limitations Assessment Steps* provides an overview of the results.

Table 43: Mental Health Parity Quantitative Treatment Limitations Assessment Steps

Classification	Step 1: Substantially All Categories Identified (Y/N)	Step 2: Predominant Value for Financial or Treatment Limitations	Mental Health Parity Assessment Results
Inpatient	N/A	N/A	N/A
Outpatient	N/A	N/A	N/A
Pharmacy	Y	Copay $3.40	Accepted
Emergency Services	N/A	N/A	N/A

Note. N/A: There is no copay or session limit for classification.

The files submitted demonstrated a copay for prescriptions and no limits or copays for inpatient or outpatient services. The $3.40 copay applied to prescriptions is consistent for medical/surgical and behavioral health services. Thus, the findings show appropriate parity for mental health services in relation to medical services.

Humana met all the requirements for the Mental Health Parity Assessment as shown in the figure that follows.

Figure 9: Mental Health Parity Assessment Results

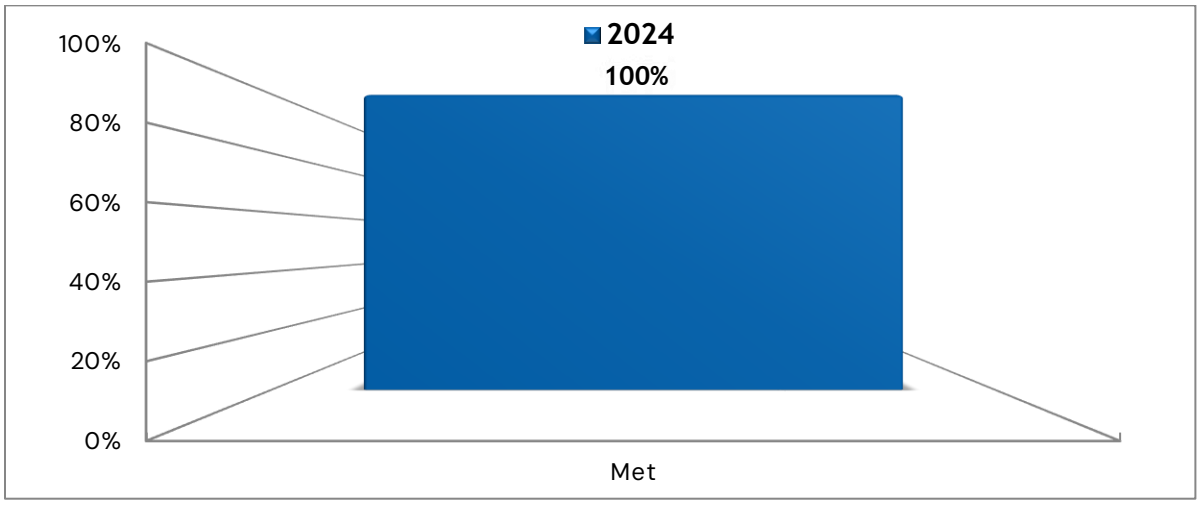


Table 44: Mental Health Parity Strengths

Strengths	Quality	Timeliness	Access to Care
Mental health parity was demonstrated in assessment of copays and financial limitations.			✓
Mental health parity assessment showed mental health services are aligned with medical/surgical financial and treatment limitations.			✓
Access and availability parity is achieved; provider network analysis and implementation plans are robust and responsive down to the local level.			✓
Utilization Management criteria and processes achieve parity.			✓
IRR incorporates both MH/SUD and medical/surgical cases.	✓		

Table 45: Mental Health Parity Weaknesses and Recommendations

Weakness	Recommendation or Quality Improvement Plans	Quality	Timeliness	Access to Care
Provider Network is not robust in certain regions; this is reflected in low scores for getting mental health services quickly on the ECHO survey.	*Recommendation: Continue to convene the Network Adequacy Workgroup. Continue the policy of not denying care based on the provider's contracted status.*			✓
Integration issues between FOCUS, the BH vendor who performs reviews when Humana associates are unable to approve a request could result in timeliness or access to care issues.	*Recommendation: Continue with training and staff support as well as JOC meetings.*			✓

VII. MENTAL HEALTH PARITY

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
VII. MENTAL HEATLH PARITY						
1. The MCO is compliant with the Mental Health Parity requirements for the Non-Quantitative Treatment Limitations.	X					Constellation Quality Health reviewed Humana's supporting documents to assess both elements of NQTL parity: comparability and stringency. Compliance with these two factors depends on a parity of process, policy, and practice. Humana's policy at this time is to not deny administratively based upon contracted status. Humana has launched a Network Adequacy Workgroup to address gaps in access to care, reflected in the low Experience of Care and Health Outcomes (ECHO) Survey results for the "Getting Treatment Quickly" composite. Humana's provider network is not robust in certain regions; this is reflected in low scores for getting mental health services quickly on the ECHO survey. *Recommendation: Continue to convene the Network Adequacy Workgroup. Continue policy of not denying care based on provider's contracted status.* Humana has delegated their mental health adverse determinations and appeals to FOCUS. Monthly Joint Operational Committee meetings have been established for vendor oversight. They continue to

Standard	Score					Comments
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						work to improve communications and streamline handoff processes, which are complicated by system incompatibility between Humana and FOCUS. Integration issues between FOCUS, the behavioral health vendor who performs reviews when Humana associates are unable to approve a request could result in timeliness or access to care issues. *Recommendation: Continue with training and staff support as well as Joint Operational Committee meetings.*
2. The MCO is compliant with the Mental Health Parity requirements for the Quantitative Treatment Limitations.	X					The files submitted demonstrated a copay for prescriptions and no limits or copays for inpatient or outpatient services. The $3.40 copay applied to prescriptions is consistent for medical surgical and behavioral health. Thus, the findings show appropriate parity for mental health services in relation to medical services.

Attachments

- Attachment 1: Initial Notice, Materials Requested for Desk Review
- Attachment 2: Materials Requested for Onsite Review
- Attachment 3: EQR Validation Worksheets

Attachment 1: Initial Notice and Materials Requested for Desk Review

December 4, 2023

Kim McElroy
Director, Market Leadership
Humana Healthy Horizons in SC
240 Harbison Blvd
Columbia, SC 29212

Dear Ms. McElroy:

At the request of the South Carolina Department of Health and Human Services (SCDHHS) this letter serves as notification that the 2024 External Quality Review (EQR) of Humana Healthy Horizons in South Carolina (Humana) is being initiated. An external quality review (EQR) conducted by Constellation Quality Health, formally The Carolinas Center for Medical Excellence, is required by your contract with SCDHHS in relation to your organization's administration of a managed care program for the Healthy Connections Medicaid recipients.

The methodology used by Constellation Quality Health 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, onsite visit and will address all contractually required services as well as follow-up of any areas of weakness identified during the previous review. The Constellation Quality Health EQR team plans to conduct the virtual onsite on February 7th and 8th. In preparation for the desk review, the items on the enclosed desk materials list should be provided to Constellation Quality Health no later than December 18, 2023.

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

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Project Manager, External Quality Review

cc: SCDHHS

External Quality Review 2023/2024

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

4. Documentation of all service planning and provider network planning activities that support the adequacy of the provider base. Please include the following:
    a. Geographic access assessments
    b. Network development plans
    c. Enrollee demographic studies
    d. Population needs assessments
    e. Calculation of provider-to-enrollee ratios (PCP and specialist)
    f. Analysis of in-network and out-of-network utilization data
    g. Provider identified limitations on panel size considered in the network assessment

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

Excel Spreadsheet Format

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

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

7. A completed Provider Network File Questionnaire (attached).

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

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

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

11. The Quality Improvement work plans for 2022, 2023 and 2024.

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

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

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

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

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

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

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

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

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

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

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

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

24. A copy of the Grievance, Complaint and Appeal logs for the months of January 2023 through November 2023.

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

26. Service availability and accessibility standards and expectations, and reports of any assessments made of provider and/or internal MCO compliance with these standards. Please include:
    a. Copies of the provider appointment availability, accessibility, and after-hours access call studies or other monitoring.
    b. Documentation of any telephone surveys, site visits, or other activities to validate provider directory information.

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

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

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

30. A copy of the provider handbook or manual.

31. A sample provider contract.

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

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

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

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

35. Results of the most recent pre-delegation and annual evaluations and ongoing monitoring activities for all delegated entities. Include a full description of the procedure and/or methodology used, and a copy of any tools used.

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

37. Electronic copies of the following files:
    a. Credentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers;
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    b. Recredentialing files for:
        i. Ten PCPs (Include two NPs acting as PCPs, if applicable);
        ii. Two OB/GYNs;
        iii. Two specialists;
        iv. Two behavioral health providers
        v. Two network hospitals; and
        vi. One file for each additional type of facility in the network.
    c. Twenty-five medical necessity denial files (acute inpatient, outpatient, and behavioral health) for the months of January 2023 through November 2023. 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 January 2023 through November 2023, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

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

These materials:

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

Attachment 2: Materials Requested for Onsite Review

External Quality Review 2024

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. A copy of the Ethics Every Day (code of conduct).
3. A copy of the letter notifying members of their restriction into the Pharmacy Lock-in Program.
4. A copy of the 2024 Humana Healthy Horizons® in South Carolina Network Development Plan.
5. Copies of the most recent results tables from the Quest geographic access evaluation/mapping for all provider types.
6. A copy of the annual delegation monitoring for Hanger Prosthetics & Orthotics.
7. The file review conducted for the annual delegation monitoring for Linkia.
8. A copy of the CAHPS Child with CCC MY2022 report, if administered.
9. All Provider Newsletters for 2023 that were not submitted initially.

Materials should be uploaded to the secure Constellation Quality Health EQR File Transfer site at: https://eqro.thecarolinascenter.org

Attachment 3: EQR Validation Worksheets

EQR Network Adequacy Validation Worksheet

EQR NETWORK ADEQUACY VALIDATION WORKSHEET	
Plan Name:	Humana
Reporting Year:	2022 - 2023
Review Performed:	2024

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

ACTIVITY 2: ASSESSMENT OF MCO NETWORK ADEQUACY METHODS		
2.1 Are the methods selected by the MCO appropriate for the state? (10)	MET	Methods aligned with State standards.
2.2 Are the methods selected by the MCO appropriate to the state Medicaid and CHIP population(s)? (10)	MET	Methods aligned with populations.
2.3 Are the methods selected by the MCO adequate to	MET	Methods generated required data for NA assessment.

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

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

ACTIVITY 4: PERFORM OVERALL VALIDATION AND REPORTING OF RESULTS

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

Points Earned	99
Possible Score	99
Validation Findings	100%

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	**Humana**
Survey Validated	**CAHPS MEMBER SATISFACTION- CHILD**
Validation Period	2022 - 2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective documented in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience identified in the report. *Documentation:* Press Ganey Child CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey tested for validity. *Documentation:* Press Ganey Child CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey tested for reliability. *Documentation:* Press Ganey Child CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation: Press* Ganey Child CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation: Press* Ganey Child CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation: Press* Ganey Child CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. *Documentation: Press* Ganey Child CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability was documented. *Documentation: Press* Ganey Child CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. *Documentation: Press* Ganey Child CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation: Press* Ganey Child CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation: Press* Ganey Child CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation: Press* Ganey Child CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation: Press* Ganey Child CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation: Press* Ganey Child CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation: Press* Ganey Child CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child response rate was 6.8% (93 out of 1,359 surveys) which is a decline over last year's rate of 7.9%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation: Press* Ganey Child CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation: Press* Ganey Child CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation: Press* Ganey Child CAHPS Report MY2022

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	Humana
Survey Validated	CAHPS MEMBER SATISFACTION- CHILD CCC
Validation Period	2022 - 2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective documented in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience identified in the report. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey tested for validity. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey tested for reliability. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability was documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	Child CCC had a response rate of 6% (84 of 1406) which is an improvement over the previous year's rate of 5.4%. This response rate, although improved, is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data were analyzed according to the work plan. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Child CCC CAHPS Report MY2022

EQR Survey Validation Worksheet

EQR Survey Validation Worksheet	
Plan Name	Humana
Survey Validated	CAHPS MEMBER SATISFACTION- ADULT
Validation Period	2022 - 2023
Review Performed	2024

Review Instructions

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

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

Survey Element		Element Met / Not Met	Comments and Documentation
1.1	Review whether there is a clear written statement of the survey's purpose(s).	MET	Survey purpose documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.2	Review that the study objectives are clear, measurable, and in writing.	MET	Study objective documented in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	MET	Survey audience identified in the report. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

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

Survey Element		Element Met / Not Met	Comments and Documentation
2.1	Assess whether the survey was tested for face validity and content validity and found to be valid	MET	Survey tested for validity. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	MET	Survey tested for reliability. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 3: REVIEW THE SAMPLING PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
3.1	Review that the definition of the study population was clearly identified.	MET	Study population was identified. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.2	Review that the sampling frame was clearly defined, free from bias, and appropriate based on survey objectives.	MET	Sampling frame was clearly defined and appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.3	Review that the sampling method appropriate to the survey purpose	MET	Sampling method was conducted according to specifications. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.4	Review whether the sample size is sufficient for the intended use of the survey.	MET	Sample size was sufficient according to CAHPS survey guidelines. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
3.5	Review that the procedures used to select the sample were appropriate and protected against bias.	MET	Procedures to select the sample were appropriate. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	MET	The specifications for response rates were in accordance with standards. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	MET	Response rate was reported and bias in generalizability was documented. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	MET	The quality plan was documented. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.2	Did the implementation of the survey follow the planned approach?	MET	Survey implementation followed the plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	MET	Procedures for missing data were developed and applied. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 6: REVIEW SURVEY IMPLEMENTATION

Survey Element		Element Met / Not Met	Comments and Documentation
6.1	Was the survey data analyzed?	MET	Survey data were analyzed. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.2	Were appropriate statistical tests used and applied correctly?	MET	Appropriate tests were utilized. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
6.3	Were all survey conclusions supported by the data and analysis?	MET	Conclusions were supported by data analysis. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

ACTIVITY 7: REVIEW SURVEY DATA ANALYSIS AND FINAL REPORT

Results Elements		Validation Comments and Conclusions
7.1	Were procedures implemented to address responses that failed edit checks?	Procedures are in place to address response issues. *Documentation: Press* Ganey Adult Population CAHPS Report MY2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	For MY2022, adult response rate was 12.6% (169 out of 1,336) which is an improvement from last year's response rate of 5.1%. This response rate is lower than the NCQA target rate of 40% and may introduce bias into the generalizability of the findings. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022 ***Recommendation:*** *Determine if additional practices can be put in place to improve response rates for the adult population.*
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to the work plan. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022
7.5	Did the final report include a comprehensive overview of the purpose, implementation, and substantive findings?	The final report included a comprehensive overview of the survey purpose, implementation, and findings/results. *Documentation:* Press Ganey Adult Population CAHPS Report MY2022

EQR Performance Measure Validation Worksheet

EQR Performance Measure Validation Worksheet	
Plan Name:	Humana
Name of PM:	ALL HEDIS MEASURES
Reporting Year:	2023
Review Performed:	2024

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS MY2022 Volume 2 Technical Specifications

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

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

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

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N1 Numerator	Data sources used to calculate the numerator (e.g., member ID, claims files, medical records, provider files, pharmacy records, including those for members who received the services outside the MCO/PIHP's network) are complete and accurate.	Met	Numerator sources were accurate.
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	Met	Calculation of rates adhered to numerator specifications.

NUMERATOR ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	Met	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	Met	Integration methods were found to be compliant.
N5 Numerator Medical Record Abstraction or Hybrid	If the hybrid method or solely medical record review was used, the results of the medical record review validation substantiate the reported numerator.	Met	Methods were reported to be compliant.

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

REPORTING ELEMENTS			
Audit Elements	Audit Specifications	Validation	Comments
R1 Reporting	Were the state specifications for reporting performance measures followed?	Met	HEDIS specifications were followed and found compliant.
Overall assessment			Plan uses NCQA certified software Cotiviti. DTS Group Audit report noted compliance for HEDIS measures.

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

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

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

AUDIT DESIGNATION
FULLY COMPLIANT

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

EQR Performance Improvement Project Validation Worksheet

EQR PIP Validation Worksheet	
Plan Name:	Humana
Name of PIP:	EPSDT: Vaccine Compliance
Reporting Year:	2022-2023
Review Performed:	2024

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

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	The MY 2021 rate was 1.82% which improved to 3.85% for the interim MY 2022. The Final Period rate was 11.5%. The goal is 36.5%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement was a result of interventions in place.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

EQR Performance Improvement Project Validation Worksheet

EQR PIP Validation Worksheet	
Plan Name:	Humana
Name of PIP:	Prenatal and Postpartum Compliance
Reporting Year:	2022-2023
Review Performed:	2024

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

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

ACTIVITY 1: ASSESS THE PIP METHODOLOGY		
Component / Standard (Total Points)	Score	Comments
8.1 Were reasonable interventions undertaken to address causes/barriers identified through data analysis and QI processes undertaken? (10)	MET	Interventions and barriers that were addressed by interventions were noted.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? (1)	MET	For MY 2022 interim rates, the results showed 84.49% for prenatal care (goal is 85.4%) and 57.59% (goal is 77.37%) for postpartum care. The final HEDIS rate is noted, however, as 92.7% for prenatal care, and 72.06% for postpartum care. The final MY 2022 rates show that prenatal care is above the goal, and the final rate for postpartum is below the goal but improving. he My 2021 rate was 1.82% which improved to 3.85% for the interim MY 2022. The Final Period rate was 11.5%. The goal is 36.5%.
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? (5)	MET	Improvement appears to be a result of interventions in place to increase visits.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? (1)	MET	Statistical analysis was included.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? (5)	NA	Unable to judge.

ACTIVITY 2: PERFORM OVERALL VALIDATION OF PIP FINDINGS

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

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

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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