2023 External Quality Review

HUMANA HEALTHY HORIZONS IN SOUTH CAROLINA

Submitted: April 5, 2023

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 2023 External Quality Review (EQR) conducted by The Carolinas Center for Medical Excellence (CCME) 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 2022 Annual Review.

The goals and objectives of the review are to:

- Determine if Humana is following service delivery requirements as mandated in the MCO contract with SCDHHS and in the federal regulations.
- Evaluate the status of deficiencies identified during the 2022 annual external quality review and any ongoing quality improvements taken to remedy those deficiencies.
- Provide feedback for potential areas of further improvement.
- Ensure contracted health care services are being delivered and are of acceptable quality.

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

Summary and Overall Findings

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

- Availability of Services *(§ 438.206, § 457.1230)*
- Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*
- Coordination and Continuity of Care *(§ 438.208, § 457.1230)*
- Coverage and Authorization of Services *(§ 438.210, § 457.1230, § 457.1228)*
- Provider Selection *(§ 438.214, § 457.1233)*
- Confidentiality *(§ 438.224)*

- Grievance and Appeal Systems *(§ 438.228, § 457.1260)*
- 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 11 Subpart D and QAPI standards as related to quality, timeliness, and access to care, CCME's review was divided into seven areas. The following is a high-level summary of the review results for those areas.

Administration:

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

Humana's general approach to policies and procedures has been revised in response to the Quality Improvement Plan for the 2022 EQR. Humana has implemented a routine policy review cycle including review of policies and procedures by the policy's Business Owner and Regulatory Compliance staff. In addition, many policies have been consolidated and/or revised. Staff are informed of policy updates by departmental leadership and can access the policies through the Enterprise Solution Point system. Despite these changes, the EQR revealed continued issues with health plan policies related to:

- Failure to include all policies on the Policy Index and failure to include a policy number and/or business owner for some policies listed on the Policy Index.
- Policies that were left in a draft format.
- Policies that did not indicate a policy number within the document.

Humana's overall staffing appears to be sufficient to ensure the health plan can provide all services and conduct all functions required by the State. However, discrepancies between information about key personnel provided by health plan documentation, reported during the onsite visit, and provided to SCDHHS made it unclear who fulfills the required key positions of Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager. Also, one staff member is serving as both the Member Services Manager and the Contract Account Manager. This is not compliant with requirements of the *SCDHHS Contract, Section 2*. The Organizational Chart does not display the operational relationships for key areas within the organization, and operational relationships of staff are not clearly and consistently documented across the health plan's Staffing Lists and Key Personnel Lists.

The Compliance Officer, along with the Compliance Committee, is responsible for oversight of the Compliance Program. Roles and responsibilities of the Compliance Officer and the Compliance Committee are included in the Compliance Plan.

The Corporate Compliance Plan outlines the goals and scope of the Compliance Program and provides information about activities to monitor for, identify, and address compliance issues and fraud, waste, and abuse (FWA). The Code of Conduct provides staff with expectations for appropriate business conduct. Routine training is provided to staff about the Compliance Program and Code of Conduct. The Compliance Plan and related policies and procedures address lines of communication, internal monitoring and auditing activities, methods of reporting compliance concerns and FWA, and processes for investigating potential compliance and/or FWA issues.

Humana's Compliance Plan, as well as policies, procedures, Program Descriptions, the Code of Conduct, etc. provide guidance about requirements for maintaining the confidentiality of Protected Health Information to ensure compliance with State and Federal laws and regulations. Humana addressed the finding from the previous EQR related to the health plan's confidentiality policy by retiring the policy and creating a new policy.

Humana's Information Systems Capabilities Assessment (ISCA) documentation demonstrates Humana's commitment to data security. The emphasis on data integrity and availability is reflected in Humana's Disaster Recovery (DR) Plan, which is tested regularly and successfully met recovery objectives in the most recent testing. Humana provides employee cybersecurity training and frequent security threat reminders to all staff.

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 2022 Healthy Horizons in South Carolina CORE Credentialing & Recredentialing Program Description and related policies address processes and requirements to ensure compliance with SCDHHS, CMS, and National Committee for Quality Assurance (NCQA) credentialing guidelines. This EQR confirmed Humana appropriately addressed a Quality Improvement Plan from the previous EQR related to credentialing policy errors and omissions. The Market Credentials Committee is overseen by the SC Chief Medical Officer, meets monthly, and uses a peer review process to make credentialing decisions. The Credentials Committee lacks a variety of specialists, such as internal medicine, general surgery, neurology, etc. Review of the submitted Credentials Committee minutes reflected the presence of a quorum for each meeting, adequate attendance by members, and documentation of discussion and results of committee votes. The samples of initial

credentialing files and recredentialing files for practitioners and organizational providers reflected full compliance with credentialing and recredentialing requirements. The file review confirmed Humana corrected issues identified during the previous EQR.

Health plan policies describe monitoring activities for provider sanctions, exclusions, limitations, and adverse actions between credentialing cycles and implementing corrective action as appropriate. Policies also describe processes for terminating a provider for quality-related reasons. It was evident that Humana corrected issues noted during the previous EQR in the policy for conducting monthly monitoring for sanctions.

Geographic access standards are appropriately defined for all providers in the Network Development Plan 2023 and in policy. A Medicaid Network Adequacy Report from December 2022 confirmed use of correct geographic access parameters for all provider types, confirms the network includes all SCDHHS-required Status 1 provider types, and documents county-by-county access. No network gaps were noted for primary care and pediatrics providers, and Humana reports they have already taken action to address gaps identified for Hematology/Oncology and Occupational Therapy.

Humana assesses provider compliance with appointment access standards by monitoring member satisfaction survey results, compliant data, and conducting annual Mystery Shopper Surveys. Health plan policy and the Provider Manual define appointment access standards. Humana's Provider Access and Availability Study Report dated September 2022 identified issues and actions to address those issues. Barriers identified in the report included incorrect provider demographic information and limited resources to continuously validate data. Humana reported that additional data validation activities are necessary for Medicaid-only providers and that Humana is recruiting additional, market-based associates to continuously monitor and update provider data.

Processes are in place to ensure the provider network is culturally competent and can meet members' cultural, language, and other special needs. Humana collects and validates member and provider demographic information and provides cultural competency education and resources for providers.

Humana's online "Find a Doctor" tool displays all required Provider Directory elements; however, the PDF versions of the regional Provider Directories submitted by Humana do not indicate providers that are not accepting new patients and contained contradictory information about how members can determine which providers are not accepting new patients.

For the provider access study focusing on primary care providers conducted by CCME, the successful call rate was 57%. This is an improvement over the previous year's rate of 55%, although not a statistically significant improvement. The majority of the unsuccessful calls were because the provider was no longer an active PCP at the location.

CCME noted that the Provider Orientation and Annual Training policy is not specific to SC. Also, the policy references a New Provider Orientation Checklist that Humana confirms is not used. This is a repeat finding from the previous EQR. Although labeled as a SC policy, Humana indicated the policy is generic to all markets and all lines of business. In addition to initial provider orientation, provider education is ongoing and provided through the Provider Manual, newsletters and other educational materials, the website, the provider portal, and through face-to-face and virtual education sessions, webinars, etc. CCME noted that the Provider Manual does not address reassignment of a member to a different PCP.

Humana's Provider Manual educates providers about preventive health and clinical practice guidelines and encourages providers to use the guidelines in decision-making and to promote positive outcomes. Providers are also educated about medical record documentation standards via the Provider Manual, and Humana evaluates provider compliance with the standards via routine Medical Record Documentation Reviews (MRDRs). QAC Minutes from 11/15/22 indicate the overall compliance average for the Q2 2022 MRDR was 76.3%. Barriers and interventions were documented.

Member Services:

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

CCME confirmed that member rights are listed in the Member Handbook, on Humana's website, and in the Provider Manual; however, a policy that listed member rights and responsibilities was not identified. Members are informed of their rights and responsibilities through the new member Welcome Packet, the Member Handbook, and the website.

Humana provides initial member education through a Welcome Packet that provides an introduction to the health plan, an overview of benefits and services, and contact information for Humana. The Member Handbook is a rich resource for members to understand health plan operations, processes, services, and requirements. The Member Handbook provides detailed information about covered benefits and exclusions, but it does not address coverage for non-hospital based rehabilitative therapies for children.

Humana educates members about preventive health services and recommendations through various forums. Activities are conducted to identify members for whom preventive/EPSDT services may be overdue and targeted outreach activities are initiated to encourage the members to obtain the recommended services.

During the review of processes and activities related to member enrollment and disenrollment, CCME noted that Humana's policy is to require members to file a grievance prior to requesting disenrollment. This is not in compliance with the requirements of the *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5*.

Humana recently conducted its first member satisfaction survey for Measurement Year 2021 (Reporting Year 2022) via SPH Analytics, a certified Consumer Assessment of Health Providers and Systems (CAHPS) survey vendor. Documentation confirmed that Humana analyzed the results, reported the results to the Quality Assurance Committee, and implemented initiatives to address problematic areas. The survey results will be reported to providers in 2023.

For grievances, the review revealed the use of outdated and incomplete definitions for the term "grievance" in some materials. No other issues were noted with documentation of grievance processes or requirements. A review of randomly selected grievance files found that the grievances were handled appropriately with no issues identified.

Quality Improvement:

42CFR §438.330, 42 CFR §457.1240 (b)

For this EQR, Humana submitted the 2022 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description. This program description provides an overview of the Quality Improvement (QI) program Humana has in place to monitor, evaluate, and facilitate improvement in the quality of health care services provided to members. The program description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships).

Annually, Humana develops a work plan to track and manage specific activities to be undertaken during the year. The 2022 and 2023 QI Work Plans were submitted for review, and included activities/tasks, objectives for each activity, responsible parties, and timeframes for completion. In the 2022 QI work plan there were several goals that had not been determined.

Humana's Internal Board/Management Team (Corporate) has ultimate responsibility for the QI Program and has delegated authority and oversight to the Corporate Quality Improvement Committee and the Quality Assurance Committee (QAC). The QAC is the local (SC) committee responsible for the operational oversight for the QI activities within the SC Plan. 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.

Humana informs providers in the Provider Manual and in the provider contract of the requirement to participate and comply with the organization's QI Program. Results of provider performance is shared through the Stars Quality Report, which provides a list of members that have a known gaps in care and is delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax.

To assess the effectiveness of the QI Program, Humana completes an evaluation annually. 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 during 2021 and 2022. A barrier analysis and recommendations for 2023 to overcome those barriers were also included. This 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), and Delegation Oversight monitoring. Also, the goals for measuring the credentialing and recredentialing activities were incorrect. These deficiencies were discussed during the onsite. Staff explained that the QI Program Evaluation was created for accreditation purposes and did not contain 12 months of data.

Performance Measure Validation: CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. 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)*. Humana utilized Dunwoody Technology Services Group (DTS Group) as their HEDIS auditor. The audit report indicated Humana uses Cotiviti as the measure vendor. The report demonstrated full compliance with standards and specifications. The MY 2021 audit review table with rates was provided for review. Due to low enrollment during this time period, several rates were not reported due to a zero denominator. Since this was the first year Humana reported HEDIS measures, no comparisons were made.

Performance Improvement Project Validation: The validation of the Performance Improvement Projects (PIPs) was conducted in accordance with the protocol developed by CMS titled, "EQR Protocol 1: Validating Performance Improvement Projects, October 2019." 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 EQR, Humana submitted two PIPs for validation. Topics included Human Papillomavirus Vaccine (HPV) and Prenatal and Postpartum Compliance. The PIPs met the validation requirements and received scores within the "High Confidence Range." The

tables that follow provide an overview of the current scores and a summary of each project.

Table 1: Human Papillomavirus Vaccine PIP

Human Papillomavirus Vaccine (HPV)	
According to the 2018 South Carolina Health Assessment, South Carolina ranks in the lowest quartile nationally for adolescents having received one or more doses of the HPV vaccine. As of April 2022, 22% of Humana's Healthy Horizons population is between the ages of 7 and 13. Well child visit compliance rates tend to decrease for this age group. Although vaccine rates continue to rise in SC, unfortunately, the rates for HPV immunizations have not increased at the rate of other vaccines in SC or the US. The importance of this PIP is to increase the complete uptake of HPV vaccines by educating adolescents, parents, and providers on the importance of preventing cancer and the common misconceptions of the HPV vaccine. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the HPV vaccines to 38.44%. The PIP report showed a rate of 1.82% in Q3, which was the MY 2021 final rate, and 3.85% in Q4, which is the interim MY 2022 rate. This was an improvement toward the goal rate of 36.5% (goal change for NCQA from 38.44% to 36.5%).	
Previous Validation Score	**Current Validation Score**
N/A	79/79=100% High Confidence in Reported Results
Interventions	
• Update the corporate HEDIS metric monitoring dashboard to include the South Carolina health plan for data monitoring and tracking towards goals. • Revise the Quality Improvement staffing to include a clinical compliance nurse and data analysts. • Launch targeted outreach campaigns specific to EPSDT program offerings. • Create targeted member education materials for targeted outreach. • Draft and distribute a provider newsletter educating providers on HPV vaccine uptake importance and Value-Added Benefits. • Draft and distribute member newsletters educating members on HPV vaccine importance, misconceptions and associated Value-Added Benefits.	

Table 2: Prenatal and Postpartum Compliance

Prenatal and Postpartum Compliance	
The objective of the project is to increase the rate of eligible women receiving timely prenatal and postpartum care. Timely prenatal care is defined as care received within 42 days of enrollment or during the first trimester. Timely postpartum care is defined as care received between 7-84 days post-delivery. The prenatal goal is to increase the compliance rate of 84.49% to 85.4% and increase the postpartum goal from 57.59% to 77.37%. Although all members will be outreached, the target population measured will be all members who delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Members who did not have a live-birth and those using Hospice services anytime during the measurement year will be excluded. For the timeliness of prenatal care measure, the final MY2021 rate reported in Q3 was 100% (although the sample included only 3 women); the interim MY2022 rate was 84.49% (target rate 85.4%). This rate declined, although the denominator for the baseline was very small, so the reliability of that rate is difficult to ascertain. For postpartum care measure, the baseline rate was 0%, which increased to 57.59% (interim MY 2022), with a goal of 77.37%.	
Previous Validation Score	**Current Validation Score**
N/A	73/74=99% High Confidence in Reported Results
Interventions	
• Enhance postpartum compliance education on the extension of the 12-month postpartum coverage through targeted Case Management services. Add a bilingual prenatal nurse to the Case Management staff. • Educate providers about 12-month postpartum coverage through provider orientations, provider newsletters, and quarterly touchpoints. • Re-brand the prenatal/postpartum education materials for targeted outreach opportunities. • Implement value added benefits that are targeted to both mom and baby for better access to resources and care. • Enhance early intervention opportunities through population identification and clinical assessments. • Update corporate HEDIS metric monitoring dashboard to include the South Carolina health plan for data monitoring and tracking towards goals. • Launch the Cultural and Linguistically Appropriate Services (CLAS) program as a structure for disparity analysis to include the prenatal/postpartum care HEDIS rates. • Include a delivery date question for the identified population on the Health Risk Assessment tool. • Add a clinical compliance nurse and data analysts to the Quality Improvement department.	

There were issues with how the PIP report documents were organized and typos that need to be resolved. One indicator for the Prenatal and postpartum Compliance PIP declined.

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 outlines the staff responsibilities, scope, and objectives for physical and behavioral health services. The pharmacy program is integrated into the UM Program. According to the 2023 Pharmacy Program Description, Humana Pharmacy Solutions is the pharmacy benefit manager. However, page 15 of the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager.

Humana's Chief Medical Officer provides oversight of the UM Program. The responsibilities of the Chief Medical Officer are to provide oversight of the UM Program, conduct Level II Reviews, participate in peer-to-peer consultations, etc. The Pharmacy Director's responsibilities entail trend monitoring, peer-to-peer collaboration, formulary oversight, etc. The Health Services Director and Behavioral Health Director provide daily operational management of the UM program.

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." For this EQR, Humana did not provide these policies with the desk materials. CCME questioned Humana staff about this during the onsite. The staff indicated the policies continue to be active and provided copies. The copies provided were still labeled as draft and contained tracked changes.

Timeliness requirements for UM determinations are included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Requests for non-urgent standard authorizations are reviewed within 14 calendar days following receipt of the request for service. Urgent requests are reviewed within 72 hours after receipt of the request.

Review staff are trained to use clinical decision support tools or various guidelines and evidence-based criteria to make medical necessity determinations. Humana's UM Program Description provided a summary of the Inter-rater Reliability (IRR) monitoring process used to assess consistency in applying the criteria and decision-making for all staff who render clinical determinations. Humana also conducts monthly case audits, weekly team meetings, and real time denial letter audits.

Prior authorization requests for medications are discussed in the Pharmacy Program description, which mentions the 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 prior authorization decision is received. There was no mention of 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.

Denial decisions were communicated in a timely manner to members and providers, and adverse benefit determination notices included the rationale for the denial and instructions for filing an appeal.

Humana addresses the process for filing and handling member appeals in Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy. Information is also provided in the Provider Manual, the Member Handbook, and on Humana's website. These documents include the process for handling standard and expedited appeal requests. Humana offers various methods for a member to request an appeal. Instructions are included for submitting an oral appeal, submitting an appeal in writing, and the online appeal submission process.

Humana provided a sample of appeal files for review. The following issues were identified in the appeal files:

- The resolution notices for five files indicated the decision was made by a specialist in the Grievance and Appeal Department or the decision was made by a medical director. However, the decisions were made by a consultant with the Network Medial Review Company.
- The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. Resolution letters contained 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 and not corrected.

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.

The Case Management Program Description and Policy SC.CLI.02, Continuity of Care and Care Transitions, provides a descriptive overview of Humana's Care Management (CM) Program. Members and providers are informed of the care management program and methods to access care management services through the website, Provider Manual, and Member Handbook. Members are referred for care management services through various resources. Referrals are accepted by fax, mail, email, and phone.

Delegation:

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

Humana has an established policy that describes requirements and processes for delegation of health plan functions and activities to external entities. The policies address oversight processes, exclusion screenings, and execution of written delegation agreements for each delegated entity. Written delegation agreements define applicable terminology and provide information about administrative requirements, laws, delegate obligations, records, auditing and oversight, sub-delegation, and potential consequences of substandard or noncompliant performance.

Corporate Delegation Compliance staff conduct annual evaluations of all delegated entities using standardized audit tools. Follow-up activities are initiated when scores are below established thresholds, and may include referral to appropriate committees and leadership, corrective actions, termination of delegation, etc. In addition to annual audits, ongoing monitoring is conducted through periodic delegate reporting and meetings. Oversight documentation submitted for review confirmed timely annual oversight as well as routine reporting and meetings for all delegates. Annual oversight documentation reflected issuance of appropriate recommendations and corrective actions as needed, and follow-up of corrective actions.

State Mandated Services:

42 CFR § Part 441, Subpart B

Policy SC.QLT.005, Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), lists EPSDT services and describes member education processes related to EPSDT services. The policy states that Humana identifies members who have gaps in care by running a report for member outreach. The policy also addresses provider education about EPSDT services through the Provider Manual and newsletters, and that the education includes relevant quality performance measures related to EPSDT services. Provider performance is monitored and tracked through population health dashboards and UM reporting. Performance metrics are reviewed by the QAC annually.

Onsite discussion revealed that claims and encounter data are used to develop the dashboards and the Stars Quality Report. The dashboards are available to providers via secured login and present member-specific gaps. This EQR confirmed that Humana addressed issues identified during the previous EQR related to tracking provider compliance with immunization administration and provision of EPSDT/Well Child services.

2022 EQR Deficiencies and Follow-Up

During the previous EQR, 16 standards were scored as “Partially Met” and eight standards were scored as “Not Met.” Following the 2022 EQR, Humana submitted a Quality

Improvement Plan to address the deficiencies. CCME reviewed and accepted the Quality Improvement Plan on June 28, 2022. The following is a high-level summary of those deficiencies:

- Many policies did not reflect consistent annual reviews by all departments. Some policies were last reviewed in 2020.
- Policy (General Contractual Conditions Confidentiality Policy)-022 states that all personal facts and circumstances concerning members or potential members are treated as privileged and confidential. The policy contains contract language but does not include processes to outline how this is conducted.
- The South Carolina requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001.
- Review of initial credentialing provider files submitted by Humana revealed:
    - For 14 of 16 files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This was a repeat finding from the Readiness Review.
    - Two initial credentialing files for nurse practitioners were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. This is a repeat finding from the Readiness Review.
    - None of the 16 initial credentialing provider files included evidence of querying the SCDHHS SC Providers Terminated for Cause List.
    - Four initial credentialing files did not include evidence of the query of the Social Security Administration's Death Master File.
- Review of recredentialing provider files submitted by Humana revealed:
    - For 14 of 16 files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee approval date.
    - Two recredentialing files for nurse practitioners were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician.
    - None of the recredentialing provider files included evidence of querying the SC Providers Terminated for Cause List.
    - Six recredentialing files did not include evidence of the query of the Social Security Administration's Death Master File.

- Thirteen initial credentialing files were submitted for organizational providers. The following issues were noted:
    - For 12 initial credentialing files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review.
    - The query of the SCDHHS Excluded Provider's Report was conducted three months after the determination date for 1 file.
    - None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.
- Fifteen recredentialing files were submitted for organizational providers. The following issues were noted:
    - For 12 recredentialing files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review.
    - None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List.
- Policy (Core Sanctions Policy)-002 states that at least every 30 days, credentialing staff review the South Carolina Excluded Providers list for newly excluded providers. However, the policy does not include that the SCDHHS SC Providers Terminated for Cause List is also monitored.
- Issues identified in Policy (Provider Training)-009 include:
    - Page two, item #1 states, “If necessary to accommodate preferences of office staff, the below may be mailed.” However, the policy does not list what may be mailed.
    - Page three of the policy lists materials that are available on the website. The list includes the “Louisiana Medicaid provider manual.” This is an issue CCME noted during the 2021 Readiness Review and recommended that Humana correct.
    - The policy makes multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist. These references were noted in item #2 on page two, item #4 on page three, and in the “Attachments/Additional Resources” heading on page four. Humana confirmed that a New Provider Orientation Checklist and New Provider Orientation and Provider Training Checklist are not used.
- Information about member benefits is included in the Provider Manual; however, the following issues were identified:

  - Page nine states audiological services are covered but does not provide limitations to this coverage or indicate hearing aids for members 21 and over are not covered.
  - Page nine states chiropractic services are covered and limited to manual manipulation of the spine to correct a subluxation. However, it does not include the limitation of six visits per year.
  - Pages 28 states Humana uses the Universal BabyNet Prior Authorization Form but does not provide any information about the BabyNet program.
  - The Provider Manual does not indicate that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. Additionally, this benefit is not included in Policy (UM – Core Benefits and Services)-007.
- Humana submitted seven grievance files for review.
  - Two of the seven files did not meet Humana's timeliness policy for sending an acknowledgement letter.
  - One file was noted as still in progress. This grievance was received on November 16, 2021, and should have been resolved by February 14, 2022. There was no information regarding a request for an extension.
  - In one file, the member complained that she was unable to locate a PCP in her area and requested a list of PCPs. Humana attempted to reach the member by phone without success. Humana sent the member resolution letter 10 days after receipt without providing the member with a list of PCPs.
- The *SCDHHS Contract, Section 15.3.1.2,* requires a variety of participating network providers to be included as members of the committee responsible for the Quality Improvement program. Humana's Quality Assurance Committee did not include any participating network practitioners.
- The Focus Health policy, Initial Case Review V 14.0 incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy did not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS MCO Policy and Procedure Guide, 4.2.24.*
- Humana had not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing.
- The *SCDHHS Contract, Section 4.2.21.2.3,* requires the health plan to publish negative Preferred Drug List (PDL) changes on Humana's website at least 30 days prior to implementation. Notices for PDL changes were found on Humana's website; however,

the effective date for the change and when the notice was published to the website were unclear. The notice contained a date at the top of the page without an explanation of what this date represents.

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

- Humana provided one appeal file. The resolution notice contained the following errors:

  - The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states "a specialist in the Grievance and Appeal Department hereby denies your plan appeal."
  - Also, the language used to describe why the denial was upheld appeared to be above the 6th grade reading level.

- There was not a specific policy or action steps planned for addressing over and underutilization. This was an issue identified during the Readiness Review.

- Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations and performing EPSDT/Well Care services. Additionally, the *SCDHHS Contract, Section 4.2.10.1* states MCOs must "Have written Policies and Procedures consistent with 42 CFR 441, Subpart B, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults."

- Humana did not implement some of the Quality Improvement Plans to address the deficiencies identified during the 2021 Readiness Review.

During the current EQR, CCME assessed the degree to which Humana implemented actions to address these deficiencies and found the Quality Improvement Plans were not implemented for the previously identified deficiencies related to:

- References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana has confirmed in both 2022 and 2023 that this checklist is not used.
- Lack of a variety of participating network providers as members of the committee responsible for the Quality Improvement activities. Humana's Quality Assurance

Committee did not contain a variety of participating network providers. For this EQR, one network practitioner and one physician consultant not participating in Humana's network had been added.

- Several appeal resolution letters did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letters stated, "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." Additionally, in several appeal resolution letters the verbiage used to describe why the denial was upheld appeared to be above the 6th grade reading level.

Conclusions

Overall, Humana met six of the eleven categories 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 11 Subpart D and QAPI standards.

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
• Availability of Services *(§ 438.206, § 457.1230)* and • Assurances of Adequate Capacity and Services *(§ 438.207, § 457.1230)*	Provider Services, Section II. B	8	7	87.5%
• 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	13	92.8%
• Provider Selection *(§ 438.214, § 457.1233)*	Provider Services, Section II. A	39	39	100%
• Confidentiality *(§ 438.224)*	Administration, Section I. E	1	1	100%
• Grievance and Appeal Systems *(§ 438.228, § 457.1260)*	Member Services, Section III. G and Utilization Management, Section V. C	20	18	90%
• Sub contractual Relationships and Delegation *(§ 438.230, § 457.1233)*	Delegation	2	2	100%

Category	Report Section	Total Number of Standards	Number of Standards Scored as "Met"	Overall Score
• Practice Guidelines *(§ 438.236, § 457.1233)*	Provider Services, Section II. D and Section II. E	11	11	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	14	11	79%

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

As noted in the table above:

- For Availability of Services and Assurances of Adequate Capacity and Services, the identified issue was related to lack of required information in the PDF versions of the regional Provider Directories.
- The process for providing a 72-hour emergency supply of medications to members in emergent situations as required by *SCDHHS Contract, Section 4.2.21.3.2* was not met for the Coverage and Authorization of Services area.
- Areas related to the Grievance and Appeal requirements, appeal files were not processed according to the SCDHHS Contract and federal requirements. Grievance terminology definitions used outdated and incomplete verbiage.
- Areas not meeting the requirements in the Quality Assessment and Performance Improvement Program included the QI Program Structure, composition of the QI Committee, and the QI Program Evaluation.

Table 4: Scoring Overview, provides an overview of the scoring of the 2023 EQR as compared to the findings of the 2022 EQR. For 2023, 197 of 215 standards were scored as "Met." Ten standards were scored as "Partially Met" and eight standards received a "Not Met" score.

Table 4: Scoring Overview

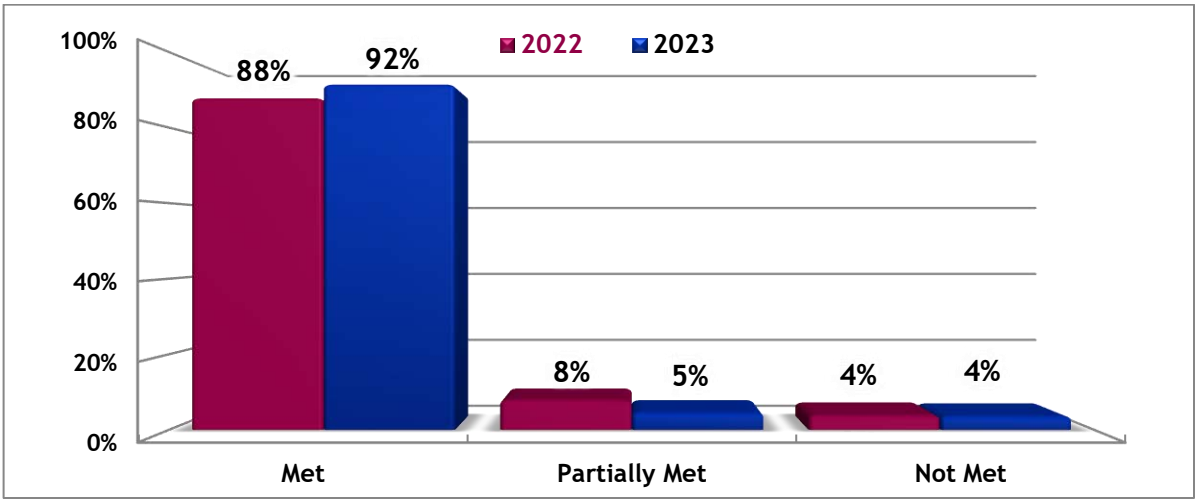
	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
Administration							
2022	38	2	0	0	0	40	95%
2023	35	2	3	0	0	40	88%
Provider Services							

	Met	Partially Met	Not Met	Not Evaluated	Not Applicable	Total Standards	*Percentage Met Scores
2022	64	6	5	1	0	76	85%
2023	73	2	1	0	0	76	96%
Member Services							
2022	21	1	0	11	0	33	95%
2023	31	1	1	0	0	33	94%
Quality Improvement							
2022	10	1	0	3	0	14	91%
2023	11	2	1	0	0	14	79%
Utilization							
2022	38	6	0	1	0	45	86%
2023	42	3	1	0	0	46	91%
Delegation							
2022	2	0	0	0	0	2	100%
2023	2	0	0	0	0	2	100%
State Mandated Services							
2022	1	0	3	0	0	4	25%
2023	3	0	1	0	0	4	75%
Totals							
2022	**174**	**16**	**8**	**16**	**0**	**214**	**88%**
2023	**197**	**10**	**8**	**0**	**0**	**215**	**92%**

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

The 2023 Annual EQR shows that Humana achieved "Met" scores for 92% of the standards reviewed. The chart that follows provides a comparison of the current review results to the 2022 review results. As the chart indicates, 5% of the standards were scored as "Partially Met," and 4% were scored as "Not Met."

Figure 1: Annual EQR Comparative Results



Scores were rounded to the nearest whole number

Strengths, Weaknesses, Recommendations, Quality Improvement Plans

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

Table 5: Evaluation of Quality

Strengths Related to Quality
• Humana has established an annual employee cybersecurity training program, and frequent security threat reminders are sent to staff.
• A robust Disaster Recovery Plan is regularly tested and incorporates site failover testing.
• In addition to regular third-party audits, Humana conducts frequent internal audits to review system operation and validate data.
• Detailed information about Humana's processes for safeguarding confidential information is included in policy.
• Credentialing and recredentialing processes are compliant with all required elements.
• A review of randomly selected grievance files found that the grievances were handled appropriately with no issues identified.
• The HEDIS measure rates reported for measure year 2021 were compliant according to the audit report.
• The Human Papillomavirus Vaccine PIP showed some improvements in the rates reported.
• Quality Assurance Committee meeting minutes were well documented.
• Denial letters were clear and understandable when identifying the reasoning for the adverse benefit determination.
• Denial letter audits are conducted in real time for quality assurance and supervision opportunities as needed for UM reviewers to ensure efficiency.

Strengths Related to Quality
• Policies thoroughly document processes for pre-delegation assessments, approval of delegation, monitoring, and annual delegation oversight. • Delegation oversight documentation submitted for review confirmed timely annual oversight for all applicable delegates, and routine reporting and meetings for all delegates. • Annual delegation oversight documentation reflected issuance of appropriate recommendations and corrective actions as needed, and follow-up of corrective actions. • Humana has established processes to monitor and track provider compliance with provision of immunizations and EPSDT/Well Care services.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Overall issues identified with health plan policies include: ○ The Policy Index does not list all policies used for conducting activities in SC and includes policies that do not specify a policy number and/or business owner. ○ Some policies were provided in draft form. ○ 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. ○ Update the Policy Index to provide a policy number and business owner for each policy listed. ○ 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. ○ Consider adding the most recent policy review date for each policy listed on the Policy Index.
• 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 positions of: ○ Administrator (CEO, COO, Executive Director, etc.) ○ Provider Services Manager	• Quality Improvement Plan: Clearly identify the individual who fulfills the role required by the *SCDHHS Contract, Section 2, Exhibit 1* for: ○ a health plan Administrator (CEO, COO, Executive Director, etc.) located within the state of SC. ○ a Provider Services Manager located within the state of SC.
• The *SCDHHS Contract, Section 2* requires one Full Time Employee (FTE) for both the Member Services Manager position and the Contract Account Manager position. Humana reported that Taffney Hooks is serving in both roles.	• Quality Improvement Plan: Hire a full time Member Services Manager located in SC.
• The responsibilities for the Interagency Liaison were not included in the job description.	• Recommendation: Include the responsibilities for the Interagency Liaison in the job description for the employee serving in this role.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• The SC Credentialing Committee Membership list incorrectly listed the Medical Director's mailing address as Atlanta Georgia.	• Correct the address for the Medical Director on the Credentialing Committee Membership list and other contact lists.
• The Organizational Chart provided by Humana 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.	• 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.
• CCME was unable to locate a policy specifying member rights and responsibilities.	• Recommendation: Develop and implement a policy that specifies the rights that are guaranteed to members as well as member responsibilities.
• Policy SC.MCC.008, Disenrollment, requires the member to file a grievance with Humana in order to disenroll. There is no contractual requirement that members must file a grievance with the health plan in order to request disenrollment. Refer to the *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5*.	• 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.
• Definitions of grievance terminology used outdated language and were incomplete.	• Quality Improvement Plan: Correct the definition of a grievance in Policy SC.GAA.001, the Member Handbook (page 10), and on Humana's website.
• The Credentials Committee membership lacks a variety of specialists such as internal medicine, general surgery, neurology, etc.	• Recommendation: Consider revising the Credentials Committee charter to require additional adult medicine specialists for committee membership, and recruit a variety of specialty practitioners.
• Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting does not define the frequency for conducting the mystery shopper call studies.	• Recommendation: Revise Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting, to indicate the frequency of conducting mystery shopper call studies.
• Policy SC.NNO.007, Provider Orientation and Annual Training, is not specific to SC and includes reference materials not used in SC.	• 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.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• CCME did not identify information in the Provider Manual regarding reassignment of a member to a different PCP. During the onsite, 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. Humana later 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." Upon review of the provided policy referenced above, it was noted that the policy was in draft form.	• Quality Improvement Plan: Develop a SC 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.
• Membership of the Corporate Physicians Clinical Practice Guidelines Committee includes internal physicians from a cross section of disciplines, QOCA leaders or designees, and approximately three local market physicians. Humana confirmed that there are four external cross-specialty physicians on the committee, but that the committee membership includes no SC physicians.	• Recommendation: Include a SC network physician as a member of the Corporate Physicians Clinical Practice Guidelines Committee.
• Policy SC.QLT.007, Medical Record Review, does not define the frequency of medical record audits.	• Recommendation: Revise Policy SC.QLT.007, Medical Record Review, to indicate the frequency of conducting medical record audits.
• The QI Program Description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships).	• Quality Improvement Plan: Update the QI Program Description and include the program's structure related to the staff assigned to the QI program and their responsibilities.
• The Quality Assurance Committee did not include a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*.	• Quality Improvement Plan: Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.
• The PIP reports had some issues with how the documents were organized and contained a few typos.	• Recommendation: Review the PIP documentation and correct the typos. Consider revising the PIP documents to improve the organization of the information displayed in the documents.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Indicator One for the Prenatal and Postpartum Compliance PIP declined.	• Recommendation: Initiate additional interventions to improve the Prenatal and Postpartum Compliance PIP measures and continue to track interim progress as new interventions are implemented.
• The 2021 - 2022 Quality Improvement Evaluation did not include the results of all activities and contained errors.	• Quality Improvement Plan: Correct the errors in the QI Program Evaluation. Include the results of all activities completed and/or an update for the ongoing activities.
• The committee responsible for the oversight of the UM Program is incorrect in the 2023 UM Program Description.	• Quality Improvement Plan: Correct the deficiencies in the UM Program Description and remove the references to the Quality Assessment Committee.
• According to the 2023 Pharmacy Program Description, Humana Pharmacy Solutions is the pharmacy benefit manager. However, page 15 of the UM Program Description and Humana's website lists Humana Centerwell Pharmacy as the pharmacy benefit manager.	• Quality Improvement Plan: Verify the pharmacy benefit manager for SC and correct the UM Program Description, Pharmacy Program Description, and/or Humana's website.
• Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 are draft policies that contained tracked changes, even though it was recommended last year that these policies be finalized.	• 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.
• Errors were noted in the Adverse Benefit Determination notices found in some of the denial files.	• Recommendation: Ensure staff are provided with and use the correct Adverse Benefit Determination notices. Review and monitor all notices to ensure the correct notices are being used.
• The following issues were identified in the appeal files: o The resolution notices for five files indicated the decision was made by a specialist in the Grievance and Appeal Department or the decision was made by a medical director. However, the decisions were made by a consultant with the Network Medial Review Company. o The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. Resolution letters included references to medical literature and medical terminology such as “tardive dyskinesia,” “neuroendocrine tumors,” and “hypereosinophilic syndrome.” o In two of the appeal files, it appeared the physician reviewer used 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 letter contains correct reviewer information and meets the SCDHHS 6th grade reading level requirement (*SCDHHS Contract, Section 3.15.12* and *42 CFR § 438.10*). Remind reviewers that other state administrative codes and fee schedules should not be used for making determinations.

Weaknesses Related to Quality	Quality Improvement / Recommendations Related to Quality
• Humana did not follow their process for closing a care management case or address the member's right to opt in or out of care management in one file.	• Recommendation: Develop a policy or include in the Care Management Program Description the process Humana uses when unable to contact members and that members are notified of their ability to opt in and out of care management program.
• The over and underutilization results, as of October 2022, did not include clear goals for the utilization measures.	• Recommendation: Include the internal goals or benchmarks in the over and underutilization reports so any areas of concern can be easily identified.
• During the current EQR, CCME assessed the degree to which Humana addressed deficiencies from the previous EQR and found the Quality Improvement Plans were not implemented for the previously identified deficiencies related to: ○ References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana has confirmed in both 2022 and 2023 that this checklist is not used. ○ Lack of a variety of participating network providers as members of the Quality Assurance Committee. For this EQR, one network practitioner and one physician consultant not participating in Humana's network had been added. ○ Appeal resolution letters not indicating that the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition, and use of verbiage in the appeal resolution letters that exceeds the 6th grade reading level.	• Quality Improvement Plan: Develop a plan of action to address and correct the deficiencies identified during this and previous EQRs. Include a monitoring component to ensure the plans are implemented timely and all deficiencies are corrected.

Table 6: Evaluation of Timeliness

Strengths Related to Timeliness
• All approval and denial files were completed in a timely manner and met contractual requirements. • Grievance files reflected timeliness of acknowledgement and resolution.

Weaknesses Related to Timeliness	Quality Improvement / Recommendations Related to Timeliness
• Three expedited appeal requests were not resolved within the 72-hour timeframe.	• Recommendation: Monitor timeliness for completing expedited appeals.

Table 7: Evaluation of Access to Care

Strengths Related to Access to Care
• Humana's Corporate Bold Goal population health initiative was established to address social determinants of health and health-related social needs for members and communities. • Members can complete their appeal requests online, and can track the process through the online portal.

Weaknesses Related to Access to Care	Quality Improvement / Recommendations Related to Access to Care
• 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)*. Additionally, each of the PDF versions of the Provider Directories included contradictory information about how members can find out which providers are not accepting new patients.	• 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.
• The Member Handbook does not indicate that non-hospital based rehabilitative therapies for children are covered and provided through the Local Education Authorities (LEA) or Private Rehabilitation Services programs. Refer to the *SCDHHS Contract, Section 4.2.22*.	• Recommendation: Revise the Member Handbook to address coverage for non-hospital based rehabilitative therapies for children.
• The *SCDHHS Contract, Section 4.2.21.3.2* requires the health plan to authorize a 72-hour emergency supply of medication to members in emergent situations until a prior authorization 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.	• 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 *SCDHHS Contract, Section 4.2.21.3.2*.
• Denial files lacked documentation of attempts to request additional information needed to make a determination.	• Recommendation: When additional information is needed to complete a prior authorization request, document the attempts to reach the provider, the provider's response, and include the timeframe for submitting the additional information.
• Instructions for filing an appeal online are not included in the Appeal section of the Member Handbook. These instructions were found in the Grievance section (page 63) of the Member Handbook.	• Recommendation: Include information regarding how a member can file an appeal online in the Appeal section of the Member Handbook.

METHODOLOGY

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

On January 9, 2023, CCME sent notification to Humana that the Annual EQR was being initiated (see *Attachment 1*). This notification included a list of materials required for a desk review and an invitation for a teleconference to allow Humana to ask questions regarding the EQR process and the requested desk materials.

The review consisted of two segments. The first was a desk review of materials and documents received from January 23, 2023, and reviewed in CCME's offices (see *Attachment 1*). These items focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Medical Management Programs. Also included in the desk review was a review of credentialing, grievance, utilization, case management, and appeal files.

The second segment was a virtual onsite review conducted on March 8th and March 9th. The onsite visit focused on areas not covered in the desk review and areas for which clarification was needed. 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 a tabular spreadsheet (*Attachment 4*).

A. Administration

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

The review for the Administration section includes policy management, health plan staffing, information management systems, compliance, program integrity, and confidentiality.

Humana's general approach to policies and procedures has been revised in response to the Quality Improvement Plan (QIP) for the 2022 EQR. *Table 8: Approach to Policies and Procedures QIP Items* lists the issues identified during the 2022 EQR and Humana's response to the QIP.

Table 8: Approach to Policies and Procedures QIP Items

Standard	EQR Comments
I A. General Approach to Policies and Procedures	
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.	The 2022 EQR found that policies and procedures are in place indicating that some of Humana's action steps in response to the Readiness Review finding were implemented. However, not at a comprehensive level. Many policies did not reflect consistent annual reviews by all departments. Some policies were last reviewed in 2020. A few examples include Policy (Continuity of Care)-010 last reviewed 11/5/2020, Policy (HPS Audit Discrepancy List Code)-001 last reviewed 11/5/2020, and Policy (Surveillance Policy)-001A last reviewed 9/7/19. Clusters of policies not reviewed within the last twelve months were found for information, technology, and data systems policies. *Quality Improvement Plan: Complete a comprehensive review of policies to reflect a current review cycle. Consolidate multiple existing policies with similar content.*
Humana Response: Humana will transition from a manual process to an automated process for the storage and review of Policies and Procedures. During the transition, Humana will use one enterprise policy template and meet with business owners to consolidate similar policies. 6/24/2022: June – August 2022 – The Medicaid team will meet with the corporate policy team to review policies and determine how to efficiently and effectively condense and combine policies using the Humana enterprise policy template. Policies will be revised according to the new process and sent to the appropriate business, legal, and regulatory compliance reviewers. August 2022 – October 2022 – Upon final approval, policies will be uploaded to ESP, Humana's Enterprise GRC Tracking system. ESP will send e-mail reminders annually to the assigned reviewers. As a part of the review, business owners will be required to use the enterprise-wide procedure template. The naming convention for each policy will be updated. The ESP Transition Tracker will be used to track progress and avoid any backlog as all policies will be reviewed at once during this project.	

The 2023 EQR and corresponding onsite discussion confirmed that 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. Information about policy changes is shared with staff by leadership from each department, and staff may access policies via Humana's Enterprise Solution Point system. Despite these changes, CCME noted continued issues with health plan policies, including:

- Humana provided several versions of its Policy Index. The first index provided listed approximately 156 policies and the second index 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 for review included policies that did not specify a policy number and/or business owner.
- Some policies were provided in a draft format. Examples include Policy QM-288-08, Provider Quality Review Process (draft watermark with a last review date of 1/27/22); Enterprise-Wide Policy #5051331 – Procedure - Government Programs PCP Request for Member Transfer_DRAFT (draft watermark with a last review date of 9/8/22); and Policy (Preauthorization List (PAL) Governance)-001 (draft watermark with issue date of 2/25/22).
- Some policies did not provide a policy number within the document, although the document file name listed a number. Examples include the document labeled as "SC.MCC.008," "SC.CDT.001," and "SC.FIN.003."

Humana's overall staffing appears to be sufficient to ensure Humana can provide all services and conduct all functions required by the State. However, discrepancies were noted in the information about key personnel provided by health plan documentation, reported during the onsite visit, and provided to SCDHHS. Because of these discrepancies, it is unclear who fulfills the requirements of the *SCDHHS Contract, Section 2* for the key position of Administrator (CEO, COO, Executive Director, etc.) and Provider Services Manager.

Also, the *SCDHHS Contract, Section 2* requires a full-time employee for the Member Services Manager position and for the Contract Account Manager position. Per information provided by Humana, one staff member is serving in both roles.

Dr. Ayo Gathing serves as Humana's Medical Director. The Medical Director is required to be located in SC per the SCDHHS Contract. The SC Credentialing Committee Membership list listed Dr. Gathing's mailing address as Atlanta Georgia. During the onsite, Dr. Gathing mentioned she had recently relocated to Lake Whylie SC.

The Organizational Chart provided by Humana 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.

Humana's Corporate Compliance Plan outlines the goals and scope of the plan and provides information about activities to monitor for, identify, and address compliance issues and fraud, waste, and abuse (FWA). Humana has developed a Code of Conduct to provide staff with expectations for appropriate business conduct. Routine training is provided to staff about the Compliance Program and Code of Conduct.

The Compliance Officer is responsible for the high-level oversight of the Compliance Program, along with the Compliance Committee. Roles and responsibilities of the Compliance Officer and the Compliance Committee are included in the Compliance Plan. The Compliance Plan and related policies and procedures address lines of communication, internal monitoring and auditing activities, methods of reporting compliance concerns and FWA, and processes for investigating potential compliance and/or FWA issues.

Humana has established a Pharmacy Lock in Program for managing members who are identified as using pharmacy services at a frequency or amount that is not medically necessary. Policy SC.RX.004, Pharmacy Lock in Program, describes procedures for identifying members for inclusion in the Program and restricting each of the members to one pharmacy. Processes for providing member notification of inclusion in the program and related instructions prior to the effective date of the restriction are addressed in the policy.

Humana's Compliance Plan, as well as policies, procedures, Program Descriptions, the Code of Conduct, etc. provide guidance about requirements for maintaining the confidentiality of Protected Health Information to ensure compliance with State and Federal laws and regulations. The findings of the 2023 review indicate that Humana addressed the finding from the previous EQR related to the health plan's confidentiality policy by retiring the policy and creating a new policy. See *Table 9: Previous Confidentiality QIP Items* for specific information about the previous finding and Humana's response to the finding.

Table 9: Previous Confidentiality QIP Items

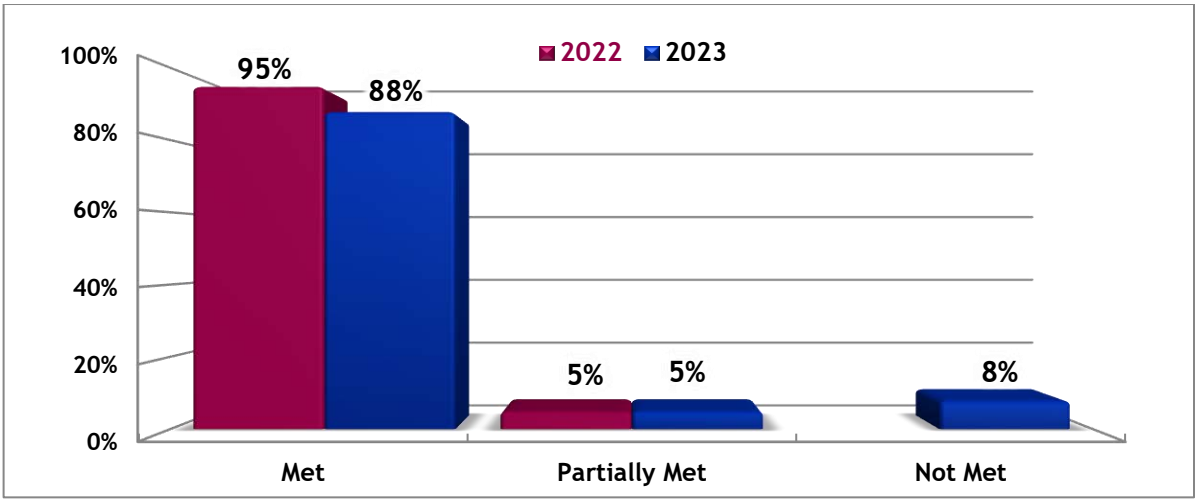
Standard	EQR Comments
I E. Confidentiality	
1. The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy.	Policy (General Contractual Conditions Confidentiality Policy)-022, states that all personal facts and circumstances concerning members or potential members are treated as privileged and confidential. The policy contains contract language but does not include processes to outline how this is conducted. *Quality Improvement Plan: Review Policy (General Contractual Conditions Confidentiality Policy)-022, and include the steps and processes used to safeguard confidential information.*
Humana Response: Humana has retired Policy (General Contractual Conditions Confidentiality Policy)-022. Humana has identified Policy (Information Protection and Acceptable Use) -011 as the appropriate policy to satisfy this requirement.	

Information Management Systems Assessment

Humana's Information Systems Capabilities Assessment (ISCA) documentation demonstrates that Humana is committed to the fundamentals of data security (confidentiality, integrity, and availability). The emphasis on data integrity and availability is reflected in Humana's Disaster Recovery (DR) Plan, which is tested regularly. The most recent testing successfully met recovery objectives. Humana's DR tests stand out because the organization performs actual disaster recovery testing, as opposed to abbreviated tabletop recovery exercises. The focus on data security is demonstrated in the company's employee cybersecurity training and frequent security threat reminders.

For 2023 EQR, 88% of the standards in the Administration section were scored as "Met," with 5% of the standards scored as "Partially Met," and 8% of the standards scored as "Not Met." *Figure 2: Administration Findings* illustrates the scoring for the 2023 EQR compared to those of the 2022 EQR.

Figure 2: Administration Findings



Percentages may not total 100% due to rounding.

Table 10: Administration Comparative Data displays standards with a change in score from the 2022 EQR to the 2023 EQR.

Table 10: Administration Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Organizational Chart / Staffing	*Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED))	Met	Not Met
	*Provider Services Manager	Met	Not Met
	*Member Services Manager	Met	Not Met
	Operational relationships of MCO staff are clearly delineated	Met	Partially Met
Confidentiality	The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 Review to 2023 Review.

Strengths

- Humana has established an annual employee cybersecurity training program, and frequent security threat reminders are sent to staff.

- A robust Disaster Recovery Plan is regularly tested and incorporates site failover testing.
- In addition to regular third-party audits, Humana conducts frequent internal audits to review system operation and validate data.
- Detailed information about Humana's processes for safeguarding confidential information are included in policy.

Weaknesses

- Overall issues identified with health plan policies include:
  - The Policy Index does not list all policies used for conducting activities in SC and includes policies that do not specify a policy number and/or business owner.
  - Some policies were provided in draft form.
  - Some policies did not provide a policy number within the document, although the document file name listed a number.
- 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 SC CEO Market Leader.
  - 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.
- 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.

- The *SCDHHS Contract, Section 2* requires one Full Time Employee (FTE) for both the Member Services Manager position and the Contract Account Manager position. Humana reported that Taffney Hooks is serving in both roles.
- The responsibilities for the Interagency Liaison were not included in the job description.
- The SC Credentialing Committee Membership list incorrectly listed the Medical Director's mailing address as Atlanta Georgia.
- The Organizational Chart provided by Humana 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.

Quality Improvement Plans

- Revise the Policy Index to include all policies followed for conducting health plan activities and functions within SC.
- Update the Policy Index to provide a policy number and business owner for each policy listed.
- 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.
- Consider adding the most recent policy review date for each policy listed on the Policy Index.
- Clearly identify the individual who fulfills the role required by the *SCDHHS Contract, Section 2, Exhibit 1* for:
  - a health plan Administrator (CEO, COO, Executive Director, etc.) located within the state of SC.
  - a Provider Services Manager located within the state of SC.
- Hire a full-time Member Services Manager located in SC.
- 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.

Recommendation

- Include the responsibilities for the Interagency Liaison in the job description for the employee serving in this role.
- Correct the address for the Medical Director on the Credentialing Committee Membership list and other contact lists.

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 encompasses credentialing and recredentialing activities, review of credentialing and recredentialing sample files, network adequacy and practitioner accessibility, initial and ongoing provider education, adoption and ongoing review of preventive health and clinical practice guidelines, processes for evaluating and ensuring continuity and coordination of care between providers, and activities for evaluating and ensuring provider adherence to medical record documentation standards.

Provider Credentialing and Selection

The 2022 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, provides specific information about processes and requirements to ensure compliance with SCDHHS, CMS, and National Committee for Quality Assurance (NCQA) credentialing guidelines.

The current EQR confirmed Humana appropriately addressed the QIP from the previous EQR related to errors/omissions from the credentialing policies. See *Table 11: Previous Provider Credentialing and Selection QIP* Items for the previously identified issues and Humana's response.

Table 11: Previous Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
1. The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements.	Humana has a written Credentialing & Recredentialing Program Description. The enterprise-wide CORE Credentialing and Recredentialing (23rd ed)-001A policy addresses general credentialing and recredentialing requirements for individual practitioners and organizational providers. Requirements specific to South Carolina Medicaid provider credentialing and

Standard	EQR Comments
	recredentialing are found in Policy (CORE Credentialing and Recredentialing)-001. The policies address most credentialing and recredentialing elements, including the scope of practitioners who must be credentialed, information to be collected and verified by the MCO, acceptable verification sources, the review and determination process, provider appeal rights, and requirements for non-discrimination against providers in high risk/high cost patient specialties. However, the South Carolina requirement for querying the SCDHHS Termination for Cause List was not included in Policy (CORE Credentialing and Recredentialing)-001. *Quality Improvement Plan: Revise Policy (CORE Credentialing and Recredentialing)-001 to specify that querying the SCDHHS Termination for Cause List is a required element for initial credentialing and recredentialing for all practitioners and organizational providers.*
Humana's Response: Humana revised Policy (CORE Credentialing and Re-credentialing)-001 to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers. 5/17/2022: Humana revised Policy (CORE Credentialing and Re-credentialing)-001 to also include a query of the Termination for Cause List for organizational providers (page 7).	

The SC Chief Medical Officer oversees the Credentials Committee, which has final decision-making authority for all credentialing and recredentialing applications. The Credentials Committee meets monthly and uses a peer review process to make credentialing decisions. The 2022 South Carolina Medicaid Credentials Committee Charter defines voting membership of the committee. The committee membership includes the practitioner types listed in required by the Committee Charter; however, the committee lacks a variety of specialists such as internal medicine, general surgery, neurology, etc. The SC Medical Director is the Credentials Committee Chairperson and votes only in the event of a tie. Review of the submitted Credentials Committee minutes reflected the presence of a quorum for each meeting, adequate attendance by members, and documentation of discussion and results of committee votes.

The samples of initial credentialing files and recredentialing files for practitioners and organizational providers reflected full compliance with credentialing and recredentialing requirements. The file review confirmed Humana corrected issues identified during the previous EQR. See *Table 12: Previous Provider Credentialing and Selection QIP Items* for

the previous issues identified in the credentialing/recredentialing file review and Humana's response.

Table 12: Previous Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	Review of initial credentialing provider files submitted by Humana revealed: •For 14 of 16 files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee approval date. This is a repeat finding from the Readiness Review. •Two initial credentialing files for nurse practitioners were submitted. Both files were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8*. This is a repeated finding from the Readiness Review. *Quality Improvement Plan: Ensure practitioner credentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure credentialing files for all nurse practitioners contain a copy of the current collaborative agreement between the nurse practitioner and the supervising physician.*
Humana's Response: Humana re-trained the Credentialing Operations staff on 04/26/2022. Humana has also updated the credentialing process to allow the committee approval letter to be generated the same day as the committee credentialing approval date. This process change will go - live 5/12/2022. 5/17/2022: The projected timeframe to complete the collection of collaborative agreements for nurse practitioners is 7/30/2022. Please see the attached SC Medicaid Nurse Practitioner Collaborative Agreement Collection Plan.	
3.1 Verification of information on the applicant, including: 3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	None of the 16 initial credentialing provider files included evidence of querying the SCDHHS SC Providers Terminated for Cause List. This was discussed during the onsite, and Humana provided the following response after completion of the onsite: "I have confirmed the verification of the "termed for cause list" was not completed for any of the credentialing and recredentialing files reviewed during the audit period. I acknowledge this is a gap in our existing process and we are working to close this gap immediately. Collection and verification of the "termed for cause list" distributed by SC DHHS is a planned area of focus that we will be re-educating and auditing more stringently going forward."

Standard	EQR Comments
	Quality Improvement Plan: Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at initial credentialing and that the credentialing files include evidence of the query as well as the date of the query.
Humana's Response: Humana revised Policy (CORE Credentialing and Re-credentialing)-001, Policy (CORE Sanctions) -002, and the Provider Sanctions Process CAQH Debarment document to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers. 5/17/2022: The inclusion of querying the SC Providers Terminated for Cause List went live on 4/11/2022. The existing SC Medicaid providers were screened against the Terminated for Cause List on 04/11/2022 and again on 05/02/2022. This will be a permanent part of the process moving forward.	
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	Four initial credentialing files did not include evidence of the query of the Social Security Administration's Death Master File. Evidence of queries of the Social Security Death Master File were submitted after the onsite for the four files in question; however, the queries indicate they were conducted on March 3, 2022, and not prior to the initial credentialing determination for the four providers. *Quality Improvement Plan: Ensure all initial practitioner credentialing files include evidence of querying the Social Security Death Master File prior to the initial credentialing determination.*
Humana's Response: Humana re-trained the Credentialing Operations staff on 04/26/2022 ensuring the verification of the Social Security Death Master File at credentialing and re-credentialing.	
4. The recredentialing process includes all elements required by the contract and by the MCO's internal policies.	Review of recredentialing provider files submitted by Humana revealed: •For 14 of 16 files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee approval date. •Two recredentialing files for nurse practitioners were submitted. Both files were missing the full collaborative agreement between the nurse practitioner and the collaborating/supervising physician. Refer to the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 2.8.* *Quality Improvement Plan: Ensure practitioner credentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure credentialing files for all nurse practitioners contain a copy of the current*

Standard	EQR Comments
	collaborative agreement between the nurse practitioner and the supervising physician.
Humana's Response: Humana re-trained the Credentialing Operations staff on 04/26/2022. Humana has also updated the credentialing process to allow the committee approval letter to be generated the same day as the committee credentialing approval date. This process change will go - live on 5/12/2022. 5/17/2022: The projected timeframe to complete the collection of collaborative agreements for nurse practitioners is 7/30/2022. Please see the attached SC Medicaid Nurse Practitioner Collaborative Agreement Collection Plan.	
4.2 Verification of information on the applicant, including: 4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	Zero of 16 recredentialing provider files included evidence of querying the SC Providers Terminated for Cause List. This was discussed during the onsite, and Humana provided the following response after completion of the onsite: "I have confirmed the verification of the "termed for cause list" was not completed for any of the credentialing and recredentialing files reviewed during the audit period. I acknowledge this is a gap in our existing process and we are working to close this gap immediately. Collection and verification of the "termed for cause list" distributed by SC DHHS is a planned area of focus that we will be re-educating and auditing more stringently going forward." *Quality Improvement Plan: Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every provider at recredentialing and that the recredentialing files include evidence of the query as well as the date of the query.*
Humana's Response: Humana re-trained the Credentialing Operations staff on 04/26/2022. Humana revised Policy (CORE Credentialing and Re-credentialing)-001, Policy (CORE Sanctions) -002, and the Provider Sanctions Process Debarment document to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers. 5/17/2022: The inclusion of querying the SC Providers Terminated for Cause List went live on 4/11/2022. The existing SC Medicaid providers were screened against the Terminated for Cause List on 04/11/2022 and again on 05/02/2022.	
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	Six recredentialing files did not include evidence of the query of the Social Security Administration's Death Master File. Evidence of queries of the Social Security Death Master File were submitted after the onsite for the six files in question; however, the queries indicate they were conducted on March 3, 2022, and not prior to the recredentialing determination for the six providers. *Quality Improvement Plan: Ensure all practitioner recredentialing files include evidence of querying the Social*

Standard	EQR Comments
	Security Death Master File prior to the recredentialing determination.
Humana's Response: Humana re-trained the Credentialing Operations staff on 04/26/2022 ensuring the verification of the Social Security Death Master File at credentialing and re-credentialing.	
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	Thirteen initial credentialing files were submitted for organizational providers. The following issues were noted: •For 12 initial credentialing files, the letter notifying the provider of the credentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review. •The query of the SCDHHS Excluded Provider's Report was conducted three months after the determination date for 1 file. •None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List. Fifteen recredentialing files were submitted for organizational providers. The following issues were noted: •For 12 recredentialing files, the letter notifying the provider of the recredentialing determination was dated prior to the credentialing committee determination date. This is a repeat finding from the 2021 Readiness Review. •None of the files included evidence of querying the SCDHHS Providers Terminated for Cause List. *Quality Improvement Plan: Ensure organizational provider credentialing and recredentialing files contain evidence that credentialing decision notification letters are sent after the date of decision by the Medical Director or Credentialing Committee. Ensure that the SCDHHS SC Providers Terminated for Cause List is queried for every organizational provider at initial credentialing and recredentialing, and that the files include evidence of the query as well as the date of the query.*
Humana's Response: Humana revised Policy (CORE Credentialing and Re-credentialing)-001, Policy (CORE Sanctions) -002, and the Provider Sanctions Process Debarment document to include the SCDHHS Termination for Cause List as a required query for initial credentialing and re-credentialing for all providers. Humana has also updated the credentialing process to allow the committee approval letter to be generated the same day as the committee credentialing approval date. 5/17/2022: The inclusion of querying the SC Providers Terminated for Cause List went live on 4/11/2022. The existing SC Medicaid providers were screened against the Terminated for Cause List on 04/11/2022 and again on 05/02/2022.	

Policy SC.CDT.01 indicates Humana may take action to limit, reduce, restrict, suspend, revoke, or terminate a practitioner's network participation for quality-related reasons. Policy QM-288-08, Provider Quality Review Process, provided by Humana after the onsite

visit, describes the process followed for terminating a provider for quality of care or service issues. As noted in the policy, the health plan's Medical Director, with assistance from the Quality Operations Compliance Department, conducts initial fact-finding activities and submits a summary of the quality issues as well as relevant records to the Peer Review Committee (PRC). The PRC conducts an evaluation and makes a recommendation for action. When a termination decision is made, the affected provider is notified and offered the opportunity for a hearing. If a hearing is requested, the hearing panel completes a written report with recommendations, which is provided to the PRC. The PRC in turn makes a recommendation to the Corporate Recommendation Review Committee for a final decision.

The 2022 Credentialing Program Description addresses monthly monitoring for provider sanctions, exclusions, limitations, adverse actions between credentialing cycles and implementing corrective action as appropriate. Policy SC.ETC.001, Ineligible Persons / Entities Screening Requirements, describes the process for routine monitoring for provider sanctions and exclusions, and 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. *Table 13: Previous Provider Credentialing and Selection QIP Items* lists issues noted during the previous EQR with Humana's policy for conducting monthly monitoring for sanctions as well as Humana's response. The policy provided for the previous EQR has been retired and a new policy created. The new policy, Policy SC.ETC.001 noted above, appropriately addresses these monitoring activities.

Table 13: Previous Provider Credentialing and Selection QIP Items

Standard	EQR Comments
II. A. Credentialing and Recredentialing	
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	Policy (Core Sanctions Policy)-002 states "Humana monitors practitioner sanctions, exclusions, and debarments between recredentialing cycles and ensures that corrective actions are undertaken and effective when it identifies occurrences of such instances." Ongoing monitoring and appropriate interventions up to and including removal from the network are implemented by collecting and reviewing Medicare/Medicaid sanctions and exclusions, licensure sanctions/limitations, and identified adverse events within 30 calendar days of release. Credentialing staff are notified of publications that include a weekly sanction pull from: •Council for Affordable Quality Healthcare (CAQH)—includes providers with state license sanctions and exclusions/sanctions

Standard	EQR Comments
	from the Office of Inspector General (OIG) List of Excluded individuals/Entities (LEIE) •System for Award Management (SAM) publications •State Medicaid exclusion notifications •Office of Personnel Management (OPM) debarment reports The policy states that at least every 30 days, credentialing staff review the South Carolina Excluded Providers list for newly excluded providers. However, the policy does not include that the SCDHHS SC Providers Terminated for Cause List is also monitored. Credentialing staff search the Provider Master Data Management (PMDM) system to confirm the identity of the sanctioned provider. Medicaid practitioners will have action taken no later than 48 hours of discovery of the sanction. Once a provider is confirmed, documentation is saved, and a certified letter is drafted to notify the provider of the termination. *Quality Improvement Plan: Revise Policy (Core Sanctions Policy)-002 to include the SCDHHS SC Provider Terminated for Cause List as a required monthly monitoring element.*
Humana's Response: Humana revised Policy (CORE Sanctions) -002 to include the SCDHHS Termination for Cause List as a required query.	

Availability of Services

During onsite discussion of processes for monitoring and assessing provider network adequacy, Humana staff reported that geographic access maps are not created; however, the health plan uses Power BI and other data analytics tools to generate multiple reports each month to identify any gaps in the geographic adequacy of the network.

Geographic access standards for Humana's provider network are outlined in the Network Development Plan 2023 and in Attachment #3 (South Carolina Medicaid Specific Standards) of Policy SC.NNO.004, Provider Network Availability and Access. The documents appropriately define the geographic access standard for primary care providers (PCPs), specialty providers, and hospitals. The South Carolina Medicaid Network Adequacy Report (Updated December 7 with data as of December 6) includes primary care and pediatrics providers and lists the correct time/distance parameters for PCPs. County-by-county access is documented. This document indicates no network gaps were identified for primary care and pediatrics providers across all counties in the network. The report confirms that Humana's network includes all SCDHHS-required Status 1

provider types, and indicates gaps were noted for Hematology/Oncology in two counties and for Occupational Therapy in one county. Onsite discussion confirmed that Humana is in negotiations with three Hematology/Oncology providers and has closed the gap for Occupational Therapy.

In addition to monitoring the geographic adequacy of the network, Humana monitors provider compliance with appointment access standards following processes outlined in Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting. These processes include monitoring member satisfaction survey results, complaint data, and conducting Mystery Shopper Surveys. CCME noted that Policy NNO 702-066-00 does not indicate the frequency of conducting mystery shopper call studies. Health plan staff confirmed they are conducted annually. Attachment 3 of Policy SC.NNO.004 and the Provider Manual define appointment access standards.

The Executive Summary Report to Humana Healthy Horizons in South Carolina Quality Assurance Committee Provider Access and Availability Study, dated September 2022, included the results of the 2022 call study. Issues identified include:

- Barriers identified in the report included "Incorrect provider demographic information and limited resources to continuously validate data." Humana staff were unable to provide a definitive explanation for the meaning of "limited resources to continuously validate data" during onsite discussion, and the report did not appear to include an intervention to address this barrier. After completion of the onsite visit, Humana provided a written explanation that most network providers serve multiple lines of business and that additional data validation activities are necessary for Medicaid-only providers. The response indicated Humana is recruiting additional, market-based associates to continuously monitor and update provider data.
- The report indicated the 2022 call survey included a question for specialists regarding immediate/emergent care visits and stated, "It was later determined that this is not a contractual requirement. Therefore, the response was excluded from this report. The question will be excluded from future surveys." When discussing this during the onsite visit, CCME explained that the *SCDHHS Contract, Section 6.2.3.1.5.1* states, "For specialty referrals, provide for: Emergent visits immediately upon referral." Humana staff responded that for the 2022 survey, the wording of the question related to emergent specialty visits was misleading and would be revised prior to future surveys.

The 2022 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description addresses Culturally and Linguistically Appropriate Services (CLAS) and covers Humana's activities to ensure cultural competence of its network to eliminate inequalities, health disparities, and barriers. These activities include collecting and validating member ethnicity and racial data and providing cultural competency education and resources for providers. The Provider Manual includes an

overview of Cultural Competency, explains the expectation that services are provided in a culturally competent manner, and includes a hyperlink to Humana's Cultural Competency Plan and additional provider training materials.

The online "Find a Doctor" tool displays all required Provider Directory elements. The PDF versions of the regional Provider Directories submitted by Humana do not indicate 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)*. The PDF versions of the Provider Directories were submitted for review and contained contradictory statements about how members can determine which providers are not accepting new patients. Page eight of each instructs the member to go to the website or to call Member services, yet page 13 of each states the directory includes whether providers are accepting new patients.

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, CCME conducted a provider access study focusing on primary care providers. A list of current providers was given to CCME by Humana, from which a population of 2,174 unique PCPs was identified. A sample of 175 providers was randomly selected from this population for the access study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers.

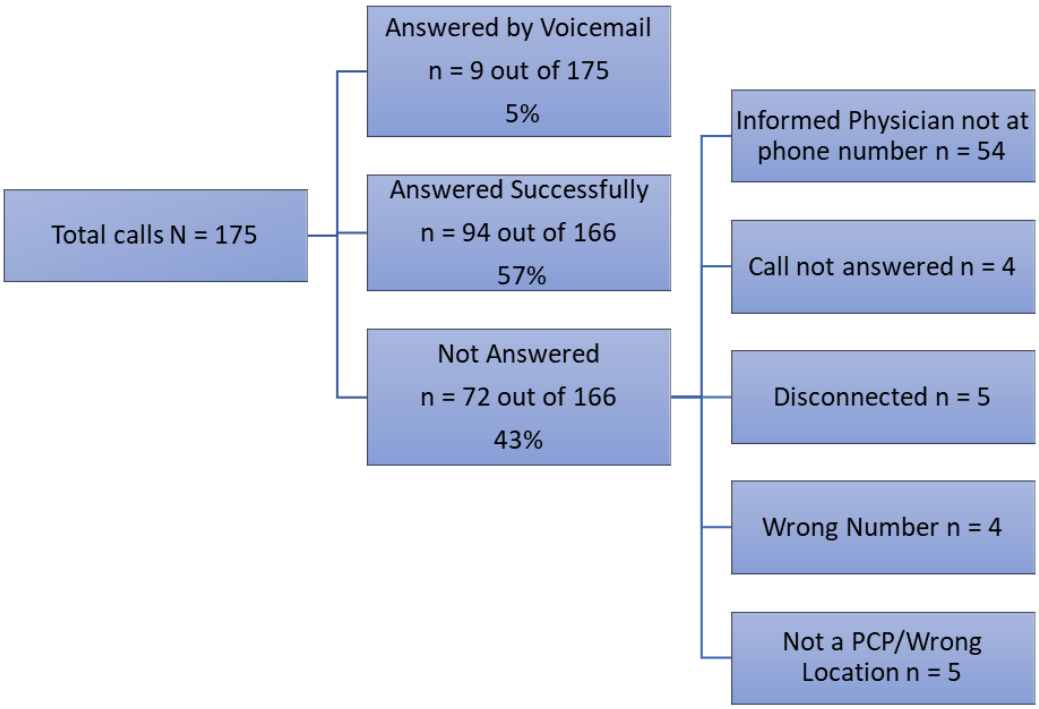
Calls were successfully answered 57% of the time (94 out of 166) when omitting calls answered by personal or general voicemail messaging services. When compared to last year's rate of 55%, this is an improvement, although it was not a statistically significant improvement (p = .718). See *Table 14: Telephonic Access Study Answer Rate Comparison*.

Table 14: Telephonic Access Study Answer Rate Comparison

Review Year	Sample Size	Answer Rate	p-value
2022	172	55%	p = .718
2023	175	57%	

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

Figure 3: Telephonic Provider Access Study Results



For the 72 calls that were not answered successfully, 54 (75%) were because the provider was no longer an active PCP at the location. For the question "Do you accept Humana?" 72 out of 94 providers (77%) confirmed that they accept Humana. Of those 72, 48 providers (67%) were accepting new Medicaid patients; eight out of the 48 (17%) indicated they have prescreening requirements. Of the eight providers with prescreening requirements, five (63%) required an application, one (12%) required a medical record review, and two (25%) required vaccine records. Regarding routine appointment availability, an appointment within 30 calendar days was noted for 25 of the 33 providers (75%) that could offer an appointment without more specific patient information to schedule the appointment.

Provider Education

42 CFR § 438.414, 42 CFR § 457.1260

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, Section VIII (Resources) of the policy lists two documents, including Sample New Provider Orientation Checklist Market and South Carolina Medicaid Annual Training Requirements. In response to CCME's request for a copy of the New Provider Orientation Checklist used for SC providers, Humana stated 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." Humana staff explained the provider orientation process and stated that an initial welcome letter is sent followed by a welcome call within 30 days. Humana provides links to all provider resources and offers one-on-one training if the provider desires.

CCME reviewed the Healthcare Provider Resource Guide which provides information about online self-service, online resources, the Availity Portal, claims, prior authorization information, and contact information. The 2022 Provider Manual and the health plan's website are additional resources for providers. The Provider Manual addresses most information providers need to understand and navigate the health plan; however, it does not include information about reassignment of a member to a different PCP. The health plan was questioned about any circumstances under which a PCP can request a member be reassigned to another PCP. Humana staff were unable to provide a clear explanation during the onsite visits, and later 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." Humana provided a copy of the policy referenced above. CCME noted the policy was in draft form.

Ongoing education is provided through the Provider Manual, newsletters and other educational materials, the website, the Availity portal, and through face-to-face and virtual education sessions/webinars, etc. Humana conducts four annual regional provider training sessions.

Table 15: Previous Provider Education QIP Items lists issues noted during the previous EQR with Humana's policy for provider education, as well as Humana's response. The policy provided for the previous EQR has been retired and a new policy was created. The new policy (Policy SC.NNO.007, Provider Orientation and Annual Training), continues to reference a New Provider Orientation Checklist that Humana confirmed is not used. This was a deficiency identified during the previous EQR.

Table 15: Provider Education QIP Items

Standard	EQR Comments
II C. Provider Education	
1. The MCO formulates and acts within policies and procedures related to initial education of providers.	Policy and Procedure (Provider Training)-009 describes processes for initial and ongoing provider education, and includes topics covered during orientation and training sessions. Provider orientation is conducted within 30 days of a provider's contract

Standard	EQR Comments
	effective date. Ongoing provider education training is conducted throughout the year for program changes via monthly in-services with PCP offices, ad hoc provider meetings and webinars, periodic newsletters, annual compliance training, etc. Issues identified in Policy (Provider Training)-009 include: •Page 2, item #1 states, "If necessary to accommodate preferences of office staff, the below may be mailed." However, the policy does not list what may be mailed. •Page 3 of the policy lists materials that are available on the website. The list includes the "Louisiana Medicaid provider manual." This is an issue CCME noted during the 2021 Readiness Review and recommended that Humana correct. •The policy makes multiple references to a New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist These references were noted in item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four. Humana confirmed that a New Provider Orientation Checklist and New Provider Orientation and Provider Training Checklist are not used. *Quality Improvement Plan: Revise Policy (Provider Training)-009 to include items that may be mailed to providers (page two, item #1). Also, remove the reference to the Louisiana Medicaid provider manual (page 3) and remove references to the New Provider Orientation Checklist/New Provider Orientation and Provider Training Checklist (item #2 on page two, item #4 on page three, and in the "Attachments/Additional Resources" heading on page four).*
Humana's Response: Humana has retired (Provider Training)-009 and updated policy (Provider Training) -001. Humana ensured there are no references to the Louisiana Medicaid Provider Manual or the Provider Orientation Checklist/New Provider Orientation Checklist.	
2. Initial provider education includes: 2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	The Provider Orientation and Training Slides document addresses covered services, member costs, EPSDT services, telehealth visits, pharmacy benefits, excluded services, and added benefits. Information about member benefits is included in the Provider Manual; however, the following issues were identified: •Page nine states audiological services are covered but does not provide limitations to this coverage or indicate hearing aids for members 21 and over are not covered. See the *SCDHHS Contract, Section 4.2.4.*

Standard	EQR Comments
	•Page nine states chiropractic services are covered and limited to manual manipulation of the spine to correct a subluxation. However, it does not include the limitation of six visits per year. See the *SCDHHS Contract, Section 4.2.6.* •Pages 28 states Humana uses the Universal BabyNet Prior Authorization Form but does not provide any information about the BabyNet program. See the *SCDHHS Contract, Appendix E.* •The Provider Manual does not indicate that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. See the *SCDHHS Policy and Procedure Guide for Managed Care Organizations, Section 4.2.18.* Additionally, this benefit is not included in Policy (UM – Core Benefits and Services)-007. *Quality Improvement Plan: Revise the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. Revise Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting.*
Humana's Response: Humana revised the Provider Manual to include limitations of coverage for audiological services, the limitation on the number of visits for chiropractic services, information about BabyNet services, and information that newborn hearing screenings are covered when rendered to newborns in an inpatient hospital setting. Humana also revised Policy (UM – Core Benefits and Services)-007 to include newborn hearing screenings as a covered benefit when rendered to newborns in an inpatient hospital setting.	

The Corporate Physicians Clinical Practice Guidelines Committee meets twice yearly to review existing, new, and revised guidelines. The committee makes recommendations regarding the guidelines, and final approval of the guidelines is the responsibility of the CQIC. The guidelines are communicated to the health plan for presentation to the plan's QAC annually.

Membership of the Corporate Physicians Clinical Practice Guidelines Committee includes internal physicians from a cross section of disciplines, QOCA leaders or designees, and approximately three local market physicians. Humana confirmed that there are four external cross-specialty physicians on the committee, but that there are no SC physician members of the committee. The quorum is established as 50% plus one.

Humana's Provider Manual educates providers about preventive health and clinical practice guidelines and encourages providers to use the guidelines in decision-making and

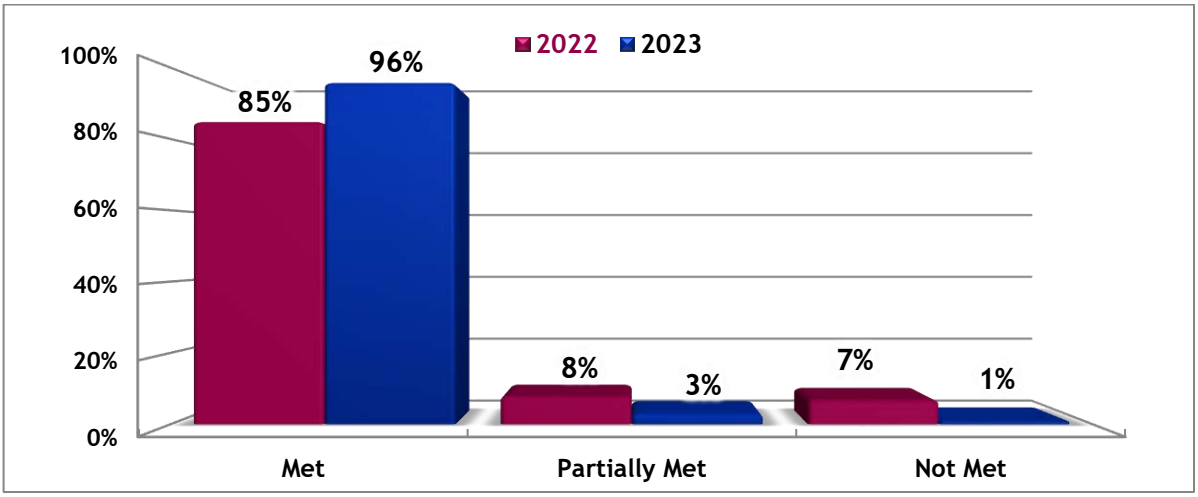
to promote positive outcomes. Providers are informed that Humana monitors provider implementation of guidelines through analysis of claim, pharmacy, and utilization data. The guidelines are available on the health plan's website and are also available from Provider Relations Representatives and the Care Management Department. Updates are provided through newsletters, Provider Manual updates, and the website.

Providers are also educated about medical record documentation standards via the Provider Manual, and Humana evaluates provider compliance with the standards via routine Medical Record Documentation Reviews (MRDRs), as described in Policy SC.QLT.007, Medical Record Review. Both the policy and the Provider Manual include the required medical record documentation elements; however, the policy does not define the frequency of conducting the MRDRs. Onsite discussion confirmed they are conducted quarterly. At the completion of each MRDR, providers are given written notification of their results, and follow-up activities, including re-education, re-auditing, etc. are conducted for those who fall below the threshold score of 85%. QAC Minutes from 11/15/22 indicate the overall compliance average for the Q2 2022 MRDR was 76.3%. Barriers and interventions were documented. At the time of the current EQR, Humana reported a medical record audit was in process.

Humana monitors the coordination of care between providers by conducting medical record reviews, monitoring HEDIS and CAHPS data, disease/case management data, appeal/grievance data, member/provider satisfaction surveys, and other internal coordination activities (UM, pharmacy, etc.).

As noted in *Figure 4: Provider Services Findings*, 96% of the Provider Services standards were scored as "Met."

Figure 4: Provider Services Findings



Percentages may not total 100% due to rounding.

Table 16: Provider Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Credentialing and Recredentialing	The MCO formulates and acts within policies and procedures for credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Met
	The credentialing process includes all elements required by the contract and by the MCO's internal policies	Not Met	Met
	Initial Credentialing—Verification of information on the applicant, including: Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Not Met	Met
	Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Not Met	Met
	Recredentialing—Verification of information on the applicant, including: Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List	Not Met	Met
	Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met	Met
	Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Not Met	Met
	Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Partially Met	Met
Adequacy of the Provider Network	The MCO maintains a provider directory that includes all requirements	Met	Partially Met

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Adequacy of the Provider Network	The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Not Evaluated	Met
Provider Education	The MCO formulates and acts within policies and procedures related to initial education of providers	Partially Met	Not Met
	Initial provider education includes: Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Partially Met	Met
	Reassignment of a member to another PCP	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- Credentialing and recredentialing processes are compliant with all required elements.
- Humana's Corporate Bold Goal population health initiative was established to address social determinants of health and health-related social needs for members and communities.

Weaknesses

- CCME confirmed the voting membership of the Credentials Committee includes practitioners with specialties of Family Medicine, Obstetrics and Gynecology, and Psychiatry, as well as a Pharmacist and a Nurse Practitioner. The committee membership includes the practitioner types listed in the committee charter; however, this committee lacks a variety of specialists such as internal medicine, general surgery, neurology, etc.
- 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)*. Additionally, 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."

- Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting, does not define the frequency for conducting the mystery shopper call studies.
- 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, Section VIII (Resources) of the policy lists two documents: the Sample New Provider Orientation Checklist Market and the South Carolina Medicaid Annual Training Requirements. Humana indicated that the SC plan does not "utilize a new provider orientation checklist for SC Medicaid new provider orientation."
- 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; however, Humana later 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." Upon review of the provided policy referenced above, it was noted that the policy was in draft form.
- Membership of the Corporate Physicians Clinical Practice Guidelines Committee includes internal physicians from a cross section of disciplines, QOCA leaders or designees, and approximately three local market physicians. Humana confirmed that there are four external cross-specialty physicians on the committee, but that the committee membership includes no SC physicians.
- Policy SC.QLT.007, Medical Record Review, describes Humana's medical record review process for assessing provider compliance with medical record documentation standards, but it does not define the frequency of medical record audits.

Quality Improvement Plans

- 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.
- Revise Policy SC.NNO.007, Provider Orientation and Annual Training, to clearly document processes for initial provider education for the South Carolina market.

- Develop an SC market policy to define the requirements and the 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.

Recommendations

- Consider revising the Credentials Committee charter to require additional adult medicine specialists for committee membership and recruit a variety of specialty practitioners.
- Revise Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting, to indicate the frequency of conducting mystery shopper call studies.
- Include a South Carolina network physician as a member of the Corporate Physicians Clinical Practice Guidelines Committee.
- Revise Policy SC.QLT.007, Medical Record Review, to indicate the frequency of conducting medical record audits.

C. Member Services

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

The review of Member Services encompasses member rights and responsibilities, member general education processes, education about preventive health and chronic disease management programs, member enrollment and disenrollment activities and requirements, member satisfaction surveys, grievance filing and processing requirements, and a review of a sample of member grievance files.

Member Rights and Responsibilities

42 CFR § 438.100, 42 CFR § 457.1220

Although CCME could not identify a policy that listed member rights and responsibilities, policy documentation confirmed that members are informed of their rights and responsibilities through the new member Welcome Packet, the Member Handbook, and on Humana's website. CCME confirmed that specific member rights are listed in the Member Handbook and on the website. Member rights and responsibilities are also included in the Provider Manual.

Member Education

42 CFR § 438.56, 42 CFR § 457.1212, 42 CFR § 438.3(j)

Humana provides education to new members through a variety of activities, including mailing a Welcome Packet no later than 14 calendar days after receipt of enrollment information. The Member Handbook serves as an educational resource for members and

includes a wealth of information members will need to understand health plan operations, processes, services, and requirements. The Welcome Packet provides an introduction to the health plan, an overview of benefits and services, contact information for Humana, and information that is available through the Member Services call center and on Humana's website. Topics addressed in the Member Handbook include processes for obtaining routine, urgent, and emergent care, second opinions, pharmacy services, etc. The Member Handbook provides detailed information about covered benefits and exclusions; however, the Member Handbook did not address coverage for non-hospital based rehabilitative therapies for children.

Humana educates members about preventive health services and recommendations through various forums, such as member outreach activities, messaging campaigns, community events, welcome calls, and the Member Handbook. The Member Handbook includes a listing of recommended services for children and the recommended periodicity of those services. Humana also conducts activities to identify members for whom services may be overdue and initiates targeted outreach activities to encourage the members to obtain the recommended services.

Member Enrollment and Disenrollment

42 CFR § 438.56

During review of processes and activities related to member enrollment and disenrollment, CCME noted that according to the Disenrollment Policy (SC.MCC.008), Humana requires members to file a grievance prior to requesting disenrollment. The *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5,* includes no requirement that members must file a grievance with the health plan to request disenrollment.

Member Satisfaction Survey

Humana contracts with SPH Analytics, a certified Consumer Assessment of Health Providers and Systems (CAHPS) survey vendor, to conduct the member satisfaction surveys. This is the first year the CAHPS survey was administered for Humana, and the surveys were conducted for Measurement Year 2021 (Reporting Year 2022).

The response rates were 5.1% (10 of 198 surveys completed) for the adult survey, 7.9% (9 of 114) for the child survey, and 5.4% (4 of 74) for the children with chronic conditions (CCC) survey. Adult rates were above the 90th (Quality Compass) percentile for Getting Needed Care, Getting Care Quickly, Coordination of Care, and Advised to Quit Smoking. The CCC rates were also above the 90th percentile for Getting Care Quickly. The child rates were above the 90th percentile for Rating of Specialist and Coordination of Care.

Once the results of the surveys were reported by SPH Analytics, Humana analyzed the results and implemented initiatives to address identified problematic areas. Results were

reported to the Quality Assurance Committee in August 2022. Humana reported that survey results will be reported to providers in 2023.

Grievances

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

Policy SC.GAA.001, Medicaid Grievances and Appeals, provides detailed information about processes for handling grievances from receipt through resolution.

The *SCDHHS Contract, Section 9* and *42 CFR 438.400 (b)* define a grievance as "an expression of dissatisfaction about any matter other than an adverse benefit determination." When reviewing Humana's grievance documentation, it was found that Policy SC.GAA.001 and page 10 of the Member Handbook use outdated terminology when defining a grievance and the definition on Humana's website is incomplete.

No additional issues were noted with documentation of grievance processes or requirements across policies, the Member Handbook, the Provider Manual, and on Humana's website. Appropriate information was included about who can file a grievance, the timeframe allowed for filing a grievance, grievance resolution timeframes, processes for implementing extensions of the resolution timeframes, etc. A review of randomly selected grievance files found that the grievances were handled appropriately with no issues identified.

The current EQR findings indicate that Humana appropriately addressed the deficiencies identified during the previous EQR, which were related to timeliness of acknowledging and resolving grievances, and inappropriate closure of a grievance without appropriately addressing the issue. See *Table 17: Previous Grievances QIP Items* for specific information about the previously identified deficiencies and Humana's response.

Table 17: Previous Grievances QIP Items

Standard	EQR Comments
III F. Grievances	
2. The MCO applies grievance policies and procedures as formulated.	Humana submitted seven grievance files for review. •Two of the seven files did not meet Humana's timeliness policy for sending an acknowledgement letter. •One file was noted as still in progress. This grievance was received on November 16, 2021 and should have been resolved by February 14, 2022. There was no information regarding a request for an extension. •In one file, the member complained that she was unable to locate a PCP in her area and requested a list of PCPs. Humana

Standard	EQR Comments
	attempted to reach the member by phone without success. Humana sent the member resolution letter 10 days after receipt without providing the member with a list of PCPs. *Quality Improvement Plan: Review processes and timeliness standards for grievances and implement steps for performance improvements.*
Humana's Response: Humana has metrics for all the G&A timeframes that are used to monitor timeliness, and the results are monitored daily, weekly, and reported out monthly. The results are reported to the Operational Risk Management team for tracking in a dashboard format and shared at the enterprise level. When a metric is missed, the G&A team is responsible for providing the mitigation / corrective action plan to the Operational Risk Management team, along with the results. The G&A team also reports the acknowledgement and resolution letter timeliness metrics to the Quality Improvement Committee on a quarterly basis, along with action plans to improve performance when needed.	

As noted in *Figure 5: Member Services Findings*, 94% of the standards in the Member Services section of the review were scored as "Met." *Table 18: Member Services Comparative Data*, which follows, illustrates standards with a change in score from the 2022 EQR to the 2023 EQR.

Figure 5: Member Services Findings

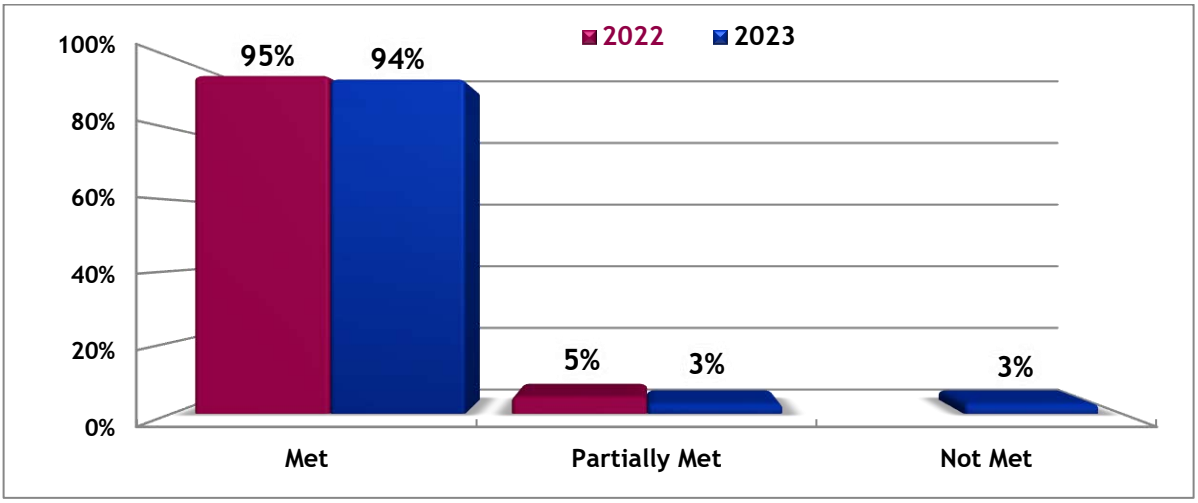


Table 18: Member Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
Member Enrollment and Disenrollment	MCO-initiated member disenrollment requests are compliant with contractual requirements.	Met	Not Met
Grievances	The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to: The definition of a grievance and who may file a grievance	Partially Met	Met
Grievances	The MCO applies grievance policies and procedures as formulated	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 Review to 2023.

Strengths

- A review of randomly selected grievance files found that the grievances were handled appropriately with no issues identified.

Weaknesses

- CCME was unable to locate a policy specifying member rights and responsibilities.
- The Member Handbook does not indicate that non-hospital based rehabilitative therapies for children are covered and provided through the Local Education Authorities (LEA) or Private Rehabilitation Services programs. Refer to the *SCDHHS Contract, Section 4.2.22*.
- Policy SC.MCC.008, Disenrollment, states when a member requests disenrollment, Customer Care Advocates 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." There is no contractual requirement that members must file a grievance with the health plan in order to request disenrollment. Refer to the *SCDHHS Contract, Sections 3.12.1.4* and *3.12.1.5*.
- Issues noted with definitions of grievance terminology include:
  - Policy SC.GAA.001 and page 10 of the Member Handbook define 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 the *SCDHHS Contract, Section 9 and 42 CFR 438.400 (b)*.

- 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." This definition omits the language "other than an adverse benefit determination."

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.
- Correct the definition of a grievance in Policy SC.GAA.001, the Member Handbook (page 10), and on Humana's website.

Recommendation

- Develop and implement a policy that specifies the rights that are guaranteed to members as well as member responsibilities.
- Revise the Member Handbook to address coverage for non-hospital based rehabilitative therapies for children.

D. Quality Improvement

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

For this EQR, Humana submitted the 2022 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description. This program description provides an overview of the Quality Improvement (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 in the program description; however, documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships) was not included. 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.

Annually, Humana develops a work plan to track and manage specific activities to be undertaken during the year. The 2022 and 2023 QI Work Plans were submitted for review. These work plans included activities/tasks, objectives for each activity, responsible parties, and timeframes for completion. In the 2022 QI work plan, there were several goals that had not been determined. CCME recommended Humana determine the measurement goals for each activity. Humana completed that recommendation and included the specific goals where applicable.

Humana's Internal Board/Management Team (Corporate) has ultimate responsibility for the QI Program and has delegated authority and oversight to the Corporate Quality Improvement Committee and the Quality Assurance Committee (QAC). The QAC is the local (SC) committee responsible for the operational oversight for the QI activities within the SC Plan. Some of the responsibilities outlined in the QI Program description include ensuring QI activities take place throughout the organization, reviewing and evaluating results of the quality and population health activities, reviewing provider network performance, and ensuring providers are included in the QI Program. The QI Lead reports quarterly on behalf of the QAC to the Corporate Quality Improvement Committee and ultimately the Internal Board.

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. The table that follows provides an overview of the previous deficiency and Humana's response to correct this deficiency.

Table 19: Previous Quality Improvement Program Deficiency

Standard	EQR Comments
IV A. The Quality Improvement (QI) Program	
2. The composition of the QI Committee reflects the membership required by the contract.	Humana's Medical Director serves as chair for the QAC. Members of the committee include senior staff department leads, directors, and managers. The *SCDHHS Contract, Section 15.3.1.2* requires a variety of participating network providers to be included as members of the QAC. However, the membership list and committee minutes for this committee did not include any participating network practitioners. Humana indicated recruitment efforts are underway to recruit providers. *Quality Improvement Plan: Recruit a variety of participating network providers as members of the Quality Assurance Committee.*
Humana's Response: Humana is currently recruiting for In-Network providers to join the Quality Assurance Committee as voting members. The Quality Director participates with Provider Contracting and Provider Engagement	

Standard	EQR Comments
	meetings. The Chief Medical Officer is actively engaged to help recruit providers. As a result, we have three providers that are showing interest in joining QAC.

The QAC meets at least quarterly and was demonstrated by the minutes provided for review. A quorum of voting members in attendance is necessary for committee action. Humana defines a quorum as 50% of the voting membership plus one. Voting members are expected to attend each meeting. In their absence, a proxy representative is required. Minutes for each meeting are maintained and clearly reflected the committee's decisions, actions, and follow-up or next steps. Minutes are reviewed and approved at the next regularly scheduled meeting. The minutes for the QAC were provided for meetings held from February 2022 through January 2023.

Humana informs providers via the Provider Manual and provider contract of the requirement to participate and comply with the organization's QI Program. Results of provider performance is shared through the Stars Quality Report. This report provides a list of members that have a known gap in care and is delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax.

Primary care providers have the option to participate in the value-based program that allows providers to earn financial incentives based on quality and clinical outcomes. The value-based program is based on the provider's panel size and their engagement. Provider performance is reviewed, and value-based reimbursements made annually.

To address the effectiveness of the QI Program, Humana completes an evaluation annually. 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 during 2021 and 2022. A barrier analysis and any recommendations for 2023 to overcome those barriers were also included. This evaluation lacked the results and analysis for the following activities:

- Timely Access/PCP Wait Times
- Network Adequacy (time and distances)
- The Utilization Management Overview Data (Over and Underutilization)
- Delegation Oversight monitoring

Also, the goal for measuring the credentialing and recredentialing activities appeared to be incorrect. The goal listed in the background information for completing the credentialing process as 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.

Performance Measure Validation

42 CFR §438.330 (c) and §457.1240 (b)

CCME conducted a validation review of the HEDIS measures following CMS protocols. This process assessed the production of these measures by the health plan to confirm reported information was valid. 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)*.

Humana utilized Dunwoody Technology Services Group (DTS Group) as their HEDIS auditor. The audit report indicated Humana uses Cotiviti as the measure vendor. The report demonstrated full compliance with standards and specifications. The MY 2021 audit review table with rates was provided for review. *Table 20: HEDIS Performance Measure Results* display the measure rates reported by Humana. Due to low enrollment during this time period, several rates were not reported due to a zero denominator. Since this was the first year Humana reported HEDIS measures, no comparisons were made.

Table 20: HEDIS Performance Measure Results

Measure/Data Element	Measure Year 2021
Effectiveness of Care: Prevention and Screening	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	
BMI percentile (Total)	85.71%*
Counseling for Nutrition (Total)	71.43%*
Counseling for Physical Activity (Total)	71.43%*
Childhood Immunization Status (CIS)	
DTaP	NR
IPV	NR
MMR	NR
HiB	NR
Hepatitis B	NR
VZV	NR
Pneumococcal Conjugate	NR
Hepatitis A	NR
Rotavirus	NR
Influenza	NR
Combo 3	NR

Measure/Data Element	Measure Year 2021
Combo 7	NR
Combo 10	NR
Immunizations for Adolescents (IMA)	
Meningococcal	NR
Tdap	NR
HPV	NR
Combination 1	NR
Combination 2	NR
Lead Screening in Children (LSC)	NR
Breast Cancer Screening (BCS)	33.33%*
Cervical Cancer Screening (CCS)	25%*
Chlamydia Screening in Women (CHL)	
Total	0%*
Effectiveness of Care: Respiratory Conditions	
Appropriate Testing for Pharyngitis (CWP)	
Total	NR
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)	NR
Pharmacotherapy Management of COPD Exacerbation (PCE)	
Systemic Corticosteroid	100%*
Bronchodilator	100%*
Asthma Medication Ratio (AMR)	
Total	100%*
Effectiveness of Care: Cardiovascular Conditions	
Controlling High Blood Pressure (CBP)	0%*
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	NR
Statin Therapy for Patients With Cardiovascular Disease (SPC)	
Received Statin Therapy (Total)	100%*
Statin Adherence 80% (Total)	100%*
Cardiac Rehabilitation (CRE)	
Cardiac Rehabilitation - Initiation (Total)	NR
Cardiac Rehabilitation - Engagement1 (Total)	NR
Cardiac Rehabilitation - Engagement2 (Total)	NR
Cardiac Rehabilitation - Achievement (Total)	NR
Effectiveness of Care: Diabetes	
Comprehensive Diabetes Care (CDC)	
HbA1c Testing	100%*
Poor HbA1c Control	0%*

Measure/Data Element	Measure Year 2021
HbA1c Control (<8%)	100%*
Eye Exams	0%*
Blood Pressure Control (<140/90)	0%*
Kidney Health Evaluation for Patients With Diabetes (KED)	
Kidney Health Evaluation for Patients With Diabetes (Total)	NR
Statin Therapy for Patients With Diabetes (SPD)	
Received Statin Therapy	NR
Statin Adherence 80%	NR
Effectiveness of Care: Behavioral Health	
Antidepressant Medication Management (AMM)	
Effective Acute Phase Treatment	NR
Effective Continuation Phase Treatment	NR
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	
Initiation Phase	NR
Continuation and Maintenance Phase	NR
Follow-up After Hospitalization for Mental Illness (FUH)	
Total - 30-Day Follow-Up	80%*
Total - 7-Day Follow-Up	60%*
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	
Total - 30-Day Follow-Up	75%*
Total - 7-Day Follow-Up	25%*
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	
Total - 30-Day Follow-Up	NR
Total - 7-Day Follow-Up	NR
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA)	
Total - 30-Day Follow-Up	0%*
Total - 7-Day Follow-Up	0%*
Pharmacotherapy for Opioid Use Disorder (POD)	
Pharmacotherapy for Opioid Use Disorder (Total)	NR
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	100%*
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)	NR
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)	NR
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	NR
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	
Blood Glucose Testing (Total)	NR
Cholesterol Testing (Total)	NR
Blood Glucose and Cholesterol Testing (Total)	NR

Measure/Data Element	Measure Year 2021
Effectiveness of Care: Overuse/Appropriateness	
Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)	NR
Appropriate Treatment for Upper Respiratory Infection (URI)	
Appropriate Treatment for Upper Respiratory Infection (Total)	NR
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (Total)	NR
Use of Imaging Studies for Low Back Pain (LBP)	NR
Use of Opioids at High Dosage (HDO)	NR
Use of Opioids From Multiple Providers (UOP)	
Multiple Prescribers	NR
Multiple Pharmacies	NR
Multiple Prescribers and Multiple Pharmacies	NR
Risk of Continued Opioid Use (COU)	
>=15 Days (Total)	NR
>=31 Days (Total)	NR
Access/Availability of Care	
Adults' Access to Preventive/Ambulatory Health Services (AAP)	
Adults' Access to Preventive/Ambulatory Health Services (Total)	91.67%*
Annual Dental Visit (ADV)	
Annual Dental Visit (Total)	NR
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)	
Initiation of AOD - Alcohol Abuse or Dependence (Total)	NR
Engagement of AOD - Alcohol Abuse or Dependence (Total)	NR
Initiation of AOD - Opioid Abuse or Dependence (Total)	NR
Engagement of AOD - Opioid Abuse or Dependence (Total)	NR
Initiation of AOD - Other Drug Abuse or Dependence (Total)	100%*
Engagement of AOD - Other Drug Abuse or Dependence (Total)	0%*
Initiation of AOD - Total (Total)	100%*
Engagement of AOD - Total (Total)	0%*
Prenatal and Postpartum Care (PPC)	
Timeliness of Prenatal Care	100%*
Postpartum Care	0%*
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	
Total	NR
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
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	NR

Measure/Data Element	Measure Year 2021
Child and Adolescent Well-Care Visits (WCV)	
Child and Adolescent Well-Care Visits (Total)	50%*

*NR – not reported due to zero denominator; * denominator 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, October 2019." 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 EQR, Humana submitted two PIPs for validation. Topics included Human Papillomavirus Vaccine (HPV) and Prenatal and Postpartum Compliance. The PIPs met the validation requirements and received scores within the "High Confidence Range." The tables that follow provide an overview of the current scores and a summary of each project.

Table 21: Human Papillomavirus Vaccine PIP

Human Papillomavirus Vaccine (HPV)	
According to the 2018 South Carolina Health Assessment, South Carolina ranks in the lowest quartile nationally for adolescents having received one or more doses of the HPV vaccine. As of April 2022, 22% of Humana's Healthy Horizons population is between the ages of 7 and 13. Well child visit compliance rates tend to decrease for this age group. Although vaccine rates continue to rise in SC, unfortunately, the rates for HPV immunizations have not increased at the rate of other vaccines in SC or the US. The importance of this PIP is to increase the complete uptake of HPV vaccines by educating adolescents, parents, and providers on the importance of preventing cancer and the common misconceptions of the HPV vaccine. The purpose of this project is to align with state and national efforts to increase the initiation and complete uptake of the HPV vaccines to 38.44%. The PIP report showed a rate of 1.82% in Q3 which was the MY 2021 final rate and 3.85% in Q4 which is the interim MY 2022 rate. This was an improvement toward the goal rate of 36.5% (goal change for NCQA from 38.44% to 36.5%).	
Previous Validation Score	**Current Validation Score**

Human Papillomavirus Vaccine (HPV)	
N/A	79/79=100% High Confidence in Reported Results
Interventions	
• Update corporate HEDIS metric monitoring dashboard to include the SC health plan for data monitoring and tracking towards goals. • Revise the Quality Improvement staffing to include a clinical compliance nurse and data analyst. • Launch targeted outreach campaigns specific to EPSDT program offerings. • Create targeted member education materials for targeted outreach. • Draft and distribute a provider newsletter educating providers on HPV vaccine uptake importance and Value-Added Benefits. • Draft and distribute member newsletters educating members on HPV vaccine importance, misconceptions and associated Value-Added Benefits.	

Table 22: Prenatal and Postpartum Compliance

Prenatal and Postpartum Compliance	
The objective of the project is to increase the rate of eligible women receiving timely prenatal and postpartum care. Timely prenatal care is defined as care received within 42 days of enrollment or during the first trimester. Timely postpartum care is defined as care received between 7-84 days post-delivery. The prenatal goal is to increase the compliance rate of 84.49% to 85.4% and increase the postpartum goal from 57.59% to 77.37%. Although all members will be outreached, the target population measured will be all members who delivered a live birth on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. Members who did not have a live-birth and those using Hospice services anytime during the measurement year will be excluded. For the timeliness of prenatal care measure, the final MY2021 rate reported in Q3 was 100% (although the sample included only 3 women); the interim MY2022 rate was 84.49% (target rate 85.4%). This rate declined, although the denominator for the baseline was very small so the reliability of that rate is difficult to ascertain. For postpartum care measure, the baseline rate was 0%, which increased to 57.59% (interim MY 2022) with a goal of 77.37%.	
Previous Validation Score	**Current Validation Score**
N/A	73/74=99% High Confidence in Reported Results
Interventions	

Prenatal and Postpartum Compliance
• Enhance postpartum compliance education on the extension of the 12-month postpartum coverage through targeted Case Management services. Include a bi-lingual prenatal nurse to the Case Management staff. • Educate providers on 12-month postpartum coverage through provider orientations, provider newsletters and quarterly touchpoints. • Re-brand the prenatal/postpartum education materials for targeted outreach opportunities. • Implement value added benefits that are targeted to both mom and baby for better access to resources and care. • Enhance early intervention opportunities through population identification and clinical assessments. • Update corporate HEDIS metric monitoring dashboard to include the SC health plan for data monitoring and tracking towards goals. • Launch the Cultural and Linguistically Appropriate Services (CLAS) program as a structure for disparity analysis to include the prenatal/postpartum care HEDIS rates. • Include a delivery date question for the identified population on the Health Risk Assessment tool. • Add a clinical compliance nurse and data analyst to the Quality Improvement department.

The PIP reports had issues with how the document was organized and typos that need to be resolved. One indicator for the Prenatal and Postpartum Compliance PIP declined. CCME provided the following recommendation for that PIP.

Table 23: Prenatal and Postpartum Compliance PIP Recommendation

Project	Section	Reason	Recommendation
Prenatal and Postpartum Compliance	Was there any documented, quantitative improvement in processes or outcomes of care?	Indicator 1 (timeliness of prenatal care) reduced from 100% to 84.49% with a goal of 85.40%. Indicator 2 (postpartum care) improved from 0% to 57.49% with a goal of 77.37%.	Initiate additional interventions to improve prenatal and postpartum care measures and continue to track interim progress as new interventions are implemented.

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

Humana met 79% of the standards in the Quality Improvement section of the review as noted in *Figure 6: Quality Improvement Findings*. Areas not meeting the requirements included the QI Program Structure, composition of the QI Committee, and the QI Program Evaluation.

Figure 6: Quality Improvement Findings

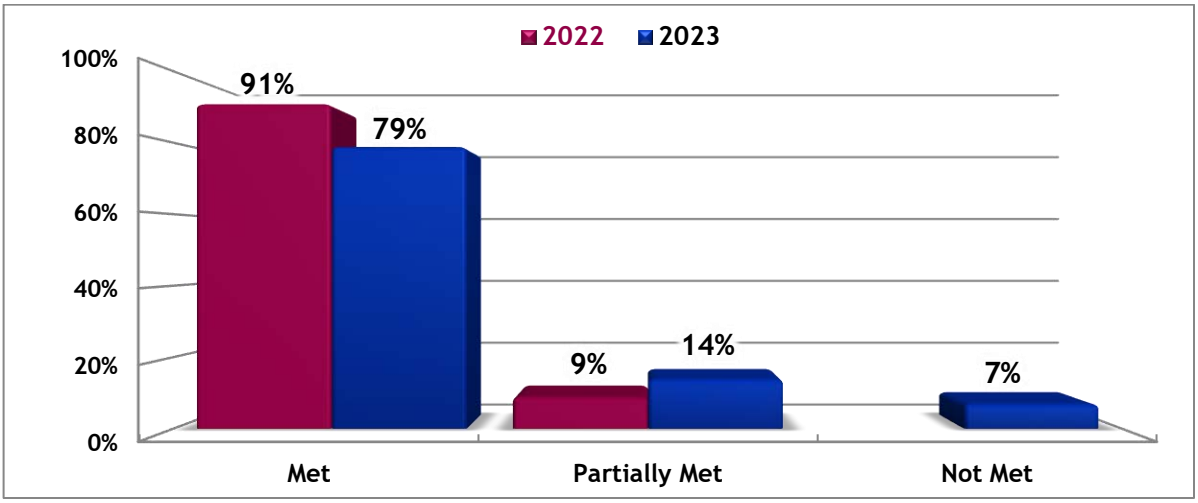


Table 24: Quality Improvement Comparative Data

SECTION	STANDARD	2022	2023
The Quality Improvement (QI) Program	The MCO has a system in place for implementing a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	Partially Met
The Quality Improvement (QI) Program	The composition of the QI Committee reflects the membership required by the contract.	Partially Met	Not Met
Performance Measures	Performance measures required by the contract are consistent with the requirements of the CMS protocol "Validation of Performance Measures."	Not Evaluated	Met
Quality Improvement Projects	Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Not Evaluated	Met
Annual Evaluation of the Quality Improvement Program	A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Partially Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- The HEDIS measure rates reported for measure year 2021 were compliant according to the audit report.
- The Human Papillomavirus Vaccine PIP showed some improvements in the rates reported.
- The committee minutes were well documented for the Quality Assurance Committee.

Weaknesses

- The QI Program Description lacked documentation regarding the program's structure (e.g., assigned staff, lines of responsibility, and reporting relationships).
- The Quality Assurance Committee did not include a variety of participating network providers as required by the *SCDHHS Contract, Section 15.3.1.2*.
- The PIP reports had some issues with how the documents were organized and contained a few typos.
- Indicator One for the Prenatal and Postpartum Compliance PIP declined.
- The 2021 – 2022 Quality Improvement Evaluation did not include the results of all activities and contained errors.

Quality Improvement Plans

- Update the QI Program Description and include the program's structure related to the staff assigned to the QI program and their responsibilities.
- Recruit a variety of participating network providers to serve as voting members of the Quality Assurance Committee.
- Correct the errors in the QI Program Evaluation and include the results of all activities completed and/or an update for the ongoing activities.

Recommendations

- Initiate additional interventions to improve the Prenatal and Postpartum Compliance PIP measures and continue to track interim progress as new interventions are implemented.
- Review the PIP documentation and correct the typos. Consider revising the PIP documents to improve the organization of the information displayed in the documents.

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 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 Humana's 2022 UM Program Description during the previous 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 in the UM Program. According to the 2023 Pharmacy Program Description, Humana Pharmacy Solutions is the pharmacy benefit manager. However, page 15 of the UM Program Description and Humana's website lists Humana Centerwell Pharmacy as the pharmacy benefit manager.

Humana's Chief Medical Officer provides oversight of the UM Program. The responsibilities of the Chief Medical Officer are to provide oversight of the UM Program, conduct Level II Reviews, participate in peer-to-peer consultations, etc. The Pharmacy Director's responsibilities entail trend monitoring, peer-to-peer collaboration, formulary oversight, etc. The Health Services Director and Behavioral Health Director provide daily operational management of the UM program.

UM Staff are comprised of clinical associates that are nurses or behavioral health professionals responsible for conducting Level I medical necessity reviews. Non-clinical associates may receive and perform data entry of requests from providers and process authorization requests that do not necessitate a clinical review.

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

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 was 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 and provided copies. The copies provided were still labeled as draft and contained tracked changes.

The timeliness for UM decisions is included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Requests for non-urgent standard authorizations are reviewed within 14 calendar days following receipt of the request for service. Urgent requests are reviewed within 72 hours after receipt of the request. During the 2022 EQR Humana had issues with other policies that contradicted the timeliness for UM decisions. Humana addressed this deficiency by removing the polices that were not applicable to their SC line of business. *Table 25: Timeliness of UM Decisions 2022 EQR Deficiency* provides an overview of this issue and Humana's response.

Table 25: Timeliness of UM Decisions 2022 EQR Deficiency

Standard	EQR Comments
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: 1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	The timeliness for Utilization Management decisions is included in Policy (UM-Timeliness of UM Determinations and Notifications)-005. Requests for non-urgent standard authorizations are reviewed within 14 calendar days following receipt of the request for service. Urgent requests are reviewed within 72 hours after receipt of the request. Focus Health, Inc. provides Behavioral Health Utilization Management Reviews. The Focus policy, Initial Case Review V 14.0, contained the timeframes for completing requests for peer reviews. This policy incorrectly listed the timeframe for completing a non-expedited review as within 45 calendar days after receipt of the request. This policy does not include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse Treatments noted in Humana's Policy (UM-Timeliness of UM Determinations)-005 and the *SCDHHS MCO Policy and Procedure Guide, 4.2.24.* *Quality Improvement Plan: Correct the timeframes for completing non-expedited reviews and include the 14-day extension requirements and the specific timeframes for completing a request for Substance Abuse treatments in the Focus policy, Initial Case Review V 14.0.*
Humana's Response: Humana has removed the Focus policy presented. The Focus policy is not applicable to SC Medicaid and Focus is not a delegated vendor for UM. The correct policy to meet this requirement is UM Determinations and Notifications- 005. 05/17/2022: Utilization Management for Behavioral Health Services is managed by Humana's internal Medicaid Utilization Management team.	

Review staff are trained to use clinical decision support tools or various guidelines and evidence-based criteria to make medical necessity determinations. Those guidelines include Milliman Care Guidelines, American Society of Addition Medicine, SC Medicaid coverage manuals, and internal Medical Clinical Coverage policies. For pharmacy authorizations, reviewers utilize references such as the American Hospital Formulary Service-Drug Information (AHFS-DI), National Comprehensive Cancer Network (NCCN) Drugs and Biologics, Compendium Truven Health Analytics Micromedex DrugDEX, Elsevier/Gold Standard Clinical Pharmacology, and Wolters Kluwer Lexi-Drugs. Review of the approval files reflect that UM reviewers utilized clinical criteria for making medical necessity determinations and the reviews were completed timely.

Humana's UM Program Description provided a summary of the Inter-rater Reliability (IRR) monitoring process used to assess consistency in applying the criteria and decision-making for all staff who render clinical determinations. For the 2022 EQR, Humana had not implemented the IRR process as noted in *Table 26: 2022 EQR Deficiency Related to IRR*.

Table 26: 2022 EQR Deficiency Related to IRR

Standard	EQR Comments
V B. Medical Necessity Determinations	
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	Humana's UM Program Description provided a summary of the Inter-rater Reliability monitoring process used to assess consistent decision-making for all staff who render clinical determinations. The goal is an overall average score of 85% for physicians and 90% for non-physician reviewers. To date Humana has not conducted IRR testing despite the policy indicating that associates with at least three months tenure are expected to complete IRR testing. *Quality Improvement Plan: Conduct IRR testing for all staff who render clinical determinations.*
Humana's Response: Humana's IRR testing is scheduled for 05/06/2022.	

The current EQR revealed that Humana conducted IRR testing and provided the results of their most recent IRR testing. One nurse reviewer received a passing score of 95%. The other UM reviewer was the test validator. During onsite discussion, it was described that a validator is utilized to ensure the validity of the test. Also, Humana stated monthly case audits, weekly team meetings, and real time denial letter audits are conducted for quality assurance and training as needed for UM reviewers.

The Pharmacy Program Description provides an overview and the structure of Humana's pharmacy program. The Preferred Drug List (PDL) identifies formulary restrictions by

indicating medications requiring prior approval, limitations, and/or step therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL. English and Spanish versions of the PDL were found on Humana's website. Changes to the PDL are posted on the website, and the change document included the date the notice was posted and the effective date for the change, as required by the *SCDHHS Contract, Section 4.2.21.2.3*. For the 2022 EQR, CCME found Humana did not meet this requirement. Following the 2022 EQR, Humana updated the template for posting PDL changes to the website. For this EQR, CCME found Humana met SCDHHS' requirement for posting negative PDL changes. The table that follows is an overview of the deficiency and Humana's response.

Table 27: 2022 EQR Deficiency Related to Pharmacy

Standard	EQR Comments
V B. Medical Necessity Determinations	
6. Pharmacy Requirements 6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	The Pharmacy Program Description provides an overview and structure of Humana's pharmacy program. The Preferred Drug List (PDL) identifies formulary restrictions by indicating medications requiring prior approval, limitations, and/or step therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL. The *SCDHHS Contract, Section 4.2.21.2.3*, requires the health plan to publish negative Preferred Drug List (PDL) changes on Humana's website at least 30 days prior to implementation. Policy (Formulary Change Notification Process)-005, defines how Humana notifies affected parties of changes to the formulary. Notices for PDL changes were found on Humana's website; however, the effective date for the change and when the notice was published on the website were unclear. The notice contained a date at the top of the page without an explanation of what this date represents. *Quality Improvement Plan: Ensure notices of negative PDL changes are posted on Humana's website at least 30 days prior to the effective date as required by the SCDHHS Contract, Section 4.2.21.2.3.*
Humana's Response: Humana has updated the template for negative PDL changes. The updated template identifies the date posted and the effective date. As of 03/22/2022 the updated template will be used.	

Prior authorization requests for medications 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 prior authorization decision is received. There was no mention of 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.

Denial decisions were communicated timely to members and providers, and adverse benefit determination notices included the rationale for the denial and instructions for filing an appeal. Humana has several letter templates used for notifying members and providers of a denial decision. Those templates provided for the previous EQR did not include information regarding an extension if an appeal is requested and contained incorrect addresses. See *Table 28: Previous Deficiency Related to Adverse Benefit Notifications* that follows.

Table 28: Previous Deficiency Related to Adverse Benefit Notifications

Standard	EQR Comments
V B. Medical Necessity Determinations	
11. Denials 11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	Humana provided several letter templates for notifying providers and members of adverse benefit determinations. The Notice of Denial and the Notice of Partial Denial letter templates did not include information that standard appeal decisions can be extended by 14 days when requested by the member or by the plan. Also, both letter templates included the address for the Office of Public Health Insurance Consumer Assistance without an explanation to the member for when to use this contact information. *Quality Improvement Plan: Correct the errors in the Notice of Denial and the Notice of Partial Denial letter templates.*
Humana's Response: Humana has rewritten the letters to include all corrections sited. The letters have been submitted to the SCDHHS for final approval.	

For this EQR, Humana provided several letter templates for notifying providers and members of adverse benefit determinations. Humana corrected the errors previously identified by CCME. However, the old notices were found in some of the denial files reviewed. Humana explained the corrected letters were approved and implemented in May/June 2022. The incorrect letters identified in the files reviewed by CCME occurred before June 2022. CCME recommends that Humana ensure staff are provided with the

corrected Adverse Benefit Determination notices and conduct an audit of all notices to ensure the correct notices are being utilized.

Appeals

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

Humana addresses processes for filing and handling member appeals in Policy SC.GAA.001, SC Medicaid Grievance and Appeal Policy. Information is also provided in the Provider Manual, the Member Handbook, and on Humana's website. These documents include the process for handling standard and expedited requests. Humana offers various methods for a member to file an appeal. Instructions are included for submitting an oral appeal, obtaining forms for submitting an appeal in writing, and the online submission process. However, the instructions for filing an appeal online are mentioned in the Grievance section (page 63) and not included in the Appeal Section of the Member Handbook.

Humana provided a sample of appeal files for review. The following issues were identified in the appeal 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.
- The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. References to medical literature and medical terminology, such as "tardive dyskinesia," "neuroendocrine tumors," and "hypereosinophilic syndrome," were included in the resolution letters.

These were the same issues identified during the 2022 EQR and not corrected. See *Table 29: 2022 Deficiency Related to Appeals*.

Table 29: 2022 Deficiency Related to Appeals

Standard	EQR Comments
V C. Appeals	
2. The MCO applies the appeal policies and procedures as formulated.	Humana provided one appeal file. The file reflected the acknowledgement and resolution was completed timely. An appropriate physician reviewed the file and made the decision to uphold the original denial. The resolution notice contained the following errors. •The resolution letter did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letter states

Standard	EQR Comments
	"a specialist in the Grievance and Appeal Department hereby denies your plan appeal." •Also, the language used to describe why the denial was upheld appeared to be above the 6th grade reading level. *Quality Improvement Plan: Develop a process for monitoring resolution notices to ensure the letter contains correct reviewer information and the language meets the SCDHHS 6th reading level.*
Humana's Response: Humana's G&A team has a process to run the Flesch- Kincaid tool after the clinical decision has been determined to ensure it meets the 6th-grade reading level.	

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.

Care Management and Coordination

42 CFR § 208, 42 CFR § 457.1230 (c)

The Case Management Program Description and Policy SC.CLI.02, Continuity of Care and Care Transitions, provides a descriptive overview and approach of Humana's Care Management (CM) Program. Members and providers are informed of the CM Program and methods to access care management services through the website, Provider Manual, and in the Member Handbook. Members are referred for care management services through various resources. Referrals are accepted by fax, mail, email, and phone.

Humana indicated that the health plan does not currently have predictive modeling software to identify members for care management and has plans to implement a predictive modeling tool by the end of the year. Hospital data, claims, direct referrals, etc. are utilized in the interim to identify members for potential care management.

Humana's CM files indicate CM activities are performed as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources. However, for one CM file reviewed, the member was engaged in CM and required an inpatient admission. The case was closed as unable to contact. Onsite discussion with the health plan described the process for closing cases when the care managers are unable to contact the members. According to Humana, two telephone attempts are made and a letter is sent within a two-week period before a member's case is closed. This process was not followed as the member's case was closed within one

week of the first initiated telephone call. Also, in one file, the member was not informed of their right to opt in or out of the care management program.

Humana conducts an annual evaluation to assess trends and to monitor any key indicator of clinical outcomes for members to evaluate strengths, weaknesses, and opportunities for improvement. The evaluation also includes the results of the members' satisfaction with CM. The data is presented to the Quality Assurance Committee for approval.

Evaluation of Over/Underutilization

Humana developed an Over and Under Utilization Data Plan policy to address a deficiency identified during the 2022 EQR (see *Table 30: Over/Underutilization 2022 Deficiency)*.

Table 30: Over/Underutilization 2022 Deficiency

Standard	EQR Comments
V E. Evaluation of Over/ Underutilization	
1. The MCO has mechanisms to detect and document under-utilization and over-utilization of medical services as required by the contract	Policies for drug utilization, the Utilization Management Data Plan and the Fraud, Research, Analytics and Concepts report for fraud management was submitted. The utilization management data plan offered some utilization indicators that will be monitored, including acute admits per 1000, inpatient days per 1000, readmission rates, ER visits per 1000 and others. All monitoring and assessment will be done by the Medical Management team and shared with the Quality Management team. There was not a specific policy or action steps planned for addressing over and underutilization. This was an issue identified during the Readiness Review. In response to this deficiency, the Utilization Management Data Plan stated that the Medical Management Committee "creates plans to mitigate when issues are identified." However, the process for how that is conducted was not clearly documented. During the onsite, staff indicated the Utilization Management Team was still building this out. *Quality Improvement Plan: Provide more detail in the Utilization Management Data Plan regarding issues identified during the monitoring of over or underutilization. The data plan should include steps If monitoring shows a trend of over or under a target value. The data plan should address the steps or process used to ensure movement toward appropriate utilization is taken, include responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.*
Humana's Response:	

Standard	EQR Comments
	Humana developed an Over and Under Utilization Data Plan policy in place of the Utilization Data plan. This policy was created by UM and the Quality team. Both teams will annually review this policy and monitor the plans over and underutilization. The policy addresses steps If monitoring shows a trend of over or under a target value. The updated policy addresses the steps used to ensure movement toward appropriate utilization is taken, includes responsible staff/department, timelines, the escalation plan, and iterative steps needed to address any unresolved issues.

Policy SC CLI 006, Over and Under Utilization Data Plan, offers procedures for utilization anomalies. Monthly data for admissions, length of stays, readmissions, ER visits, and urgent care visits were submitted. The results, as of October 2022, showed an increase for admissions, length of stay, readmissions, and ER Visits. The report submitted to the Quality Assurance Committee offers frequencies or rates for the utilization data. However, clear goals for the utilization measures were not provided. Without goals or target rates, concerns may not be identified in terms of being over or under a goal.

For this EQR, 91% of the standards in the Utilization Management section received a "Met" score, 7% of the standards received a "Partially Met" score, and 2% received a "Not Met" score. The figure and table that follow provide a comparison of the 2022 EQR review scores to the 2023 scores.

Figure 7: Utilization Management Findings

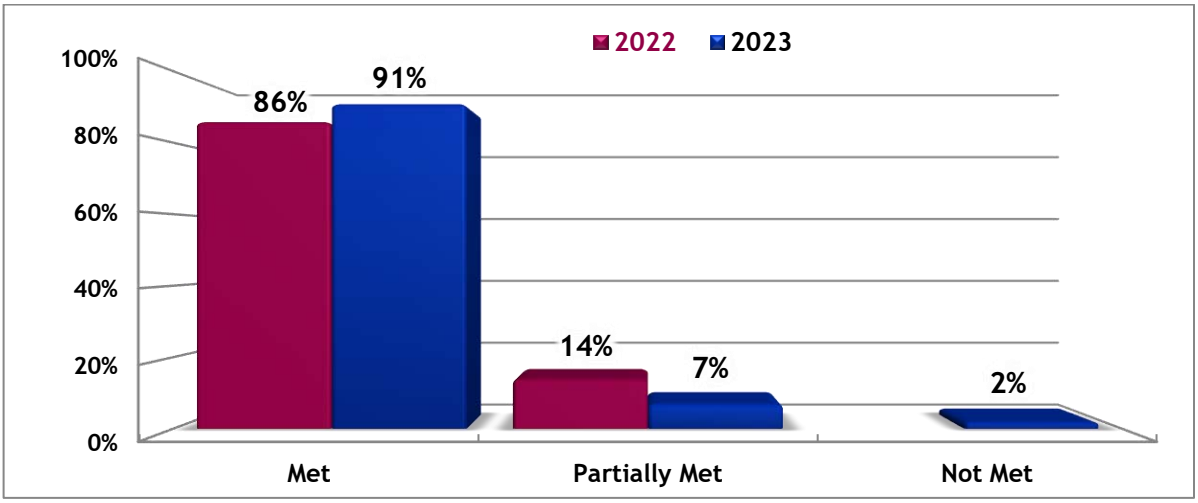


TABLE 31: Utilization Management Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
The Utilization Management (UM) Program	The MCO formulates and acts within policies and procedures that describe its utilization management program	Met	Partially Met
	timeliness of UM decisions, initial notification, and written (or electronic) verification	Partially Met	Met
Medical Necessity Determinations	Utilization management standards/criteria are consistently applied to all members across all reviewers	Partially Met	Met
	Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	Partially Met	Met
	If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Partially Met
	Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Partially Met	Met
Appeals	The MCO applies the appeal policies and procedures as formulated	Partially Met	Not Met
Over/Underutilization	The MCO has mechanisms to detect and document over utilization and under-utilization of medical services as required by the contract	Partially Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 to 2023.

Strengths

- All approval files were completed in a timely manner according to contractual requirements.
- Denial letters were clear and understandable in identifying the rationale for the adverse benefit determination.
- Members can complete their appeal requests online and can track the process through the online portal.

- Denial letter audits are conducted in real time for quality assurance and supervision opportunities as needed for UM reviewers.

Weaknesses

- The committee responsible for the oversight of the UM Program is incorrect in the 2023 UM Program Description.
- According to the 2023 Pharmacy Program Description, Humana Pharmacy Solutions is the pharmacy benefit manager. However, page 15 of the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager.
- Policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002 were draft policies that contained tracked changes even though it was recommended last year that these policies be finalized.
- *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 prior authorization 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.
- The denial files lacked documentation of the attempts to request additional information needed to make a determination.
- The Adverse Benefit Determination notices found in some of the denial files contained errors.
- The instructions for filing an appeal online are not included in the Appeal section of the Member Handbook. These instructions were found in the Grievance section (page 63) of the Member Handbook.
- The following issues were identified in the appeal 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.
    - The language used to describe why the decision was upheld or overturned appeared to be above the 6th grade reading level for nine files. Resolution letters included references to medical literature and medical terminology such as "tardive dyskinesia," "neuroendocrine tumors," and "hypereosinophilic syndrome."

  <u>These were the same issues identified during the 2022 EQR and not corrected.</u>

    - Three expedited appeal requests were not resolved within the 72-hour timeframe.

- In two of the appeal files, it appeared the physician reviewer used a KY administrative code and a KY fee schedule for making the determination.

- Humana did not follow their process for closing a care management case or address the member's right to opt in or out of case management in one file.
- The over and underutilization results, as of October 2022, results did not include clear goals for the utilization measures.

Quality Improvement Plans

- 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.
- Review policies (Preauthorization List (PAL) Governance)-001 and (Preauthorization List (PAL) Governance)-002, finalize the tracked changes, and remove the draft watermark.
- Include the process followed to authorize a 72-hour supply of medication to members in emergent situations as required by the *SCDHHS Contract, Section 4.2.21.3.2* in a policy and the Pharmacy Program Description.
- Develop a process for monitoring resolution notices to ensure the letter contains correct reviewer information and meets the SCDHHS 6th grade reading level requirement (*SCDHHS Contract, Section 3.15.12* and *42 CFR § 438.10*).
- Monitor timeliness for completing expedited appeals and remind reviewers that other state administrative codes and fee schedules should not be used for making determinations.

Recommendations

- When additional information is needed to complete a prior authorization request, document the attempts to reach the provider, the provider's response, and the timeframe for submitting the additional information.
- Ensure staff are provided with and use the correct Adverse Benefit Determination notices. Review and monitor all notices to ensure the correct notices are being used.
- Include information about how a member can file an appeal online in the Appeal section of the Member Handbook.
- Develop a policy or include in the Care Management Program Description the process Humana uses when unable to contact members, and that members are notified of their ability to opt in and out of CM.

- Include the internal goals or benchmarks in the over and underutilization reports so any areas of concern can be easily identified.

F. Delegation

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

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

Humana reported delegation agreements with 20 entities, as shown in *Table 32: Delegated Entities and Services*.

Table 32: Delegated Entities and Services

Delegated Entities	Delegated Services
InforMedia Group, Inc. dba CareNet Healthcare Services	24/7 nurse advice hotline
Focus Health Inc. dba Focus Behavioral Health Inc.	Appeal Determinations, Utilization Management
Network Medical Review Company, LTD	Appeal Determinations, Utilization Management
Braillet Corporation	ASL and verbal translation services
Streamline Verify	Background checks
•AnMed Health •Medical University Hospital Authority/MUSC Medical Center •Prisma Health University Medical Group •Self Regional Healthcare •South Carolina Department of Mental Health •St. Francis Physician Services •United Physicians Inc.	Credentialing
Go365, LLC	Health risk Assessments
Symphony Performance Health, Inc. dba SPH Analytics	Member surveys
The MidIsland Group USA, LLC	Print and mail fulfillment
Voiance Language Services	Telephonic translation services
Harris Rothenberg, International	Tobacco cessation and weight management coaching
Modivcare Solutions, LLC	VAB, non-emergent transportation services, claims processing

Delegated Entities	Delegated Services
Block Vision, Inc. dba Superior Vision Benefit Management, Inc.	Vision network management, claims processing, credentialing
United Language Group, Inc.	Written translation services

Policy SC.DCO.001, Delegation Policy, describes requirements and processes for delegation of health plan medical, dental, vision, and behavioral health functions and activities to external entities. The policy addresses oversight processes followed by Delegation Compliance staff, exclusion screenings, and execution of written delegation agreements for each delegated entity that specify the delegated activities, health plan and delegate responsibilities, and consequences for failure to fulfill obligations. Policy SC.CDT.001, Credentialing, Recredentialing, and Ongoing Sanction Monitoring, addresses requirements specific to delegation of credentialing activities.

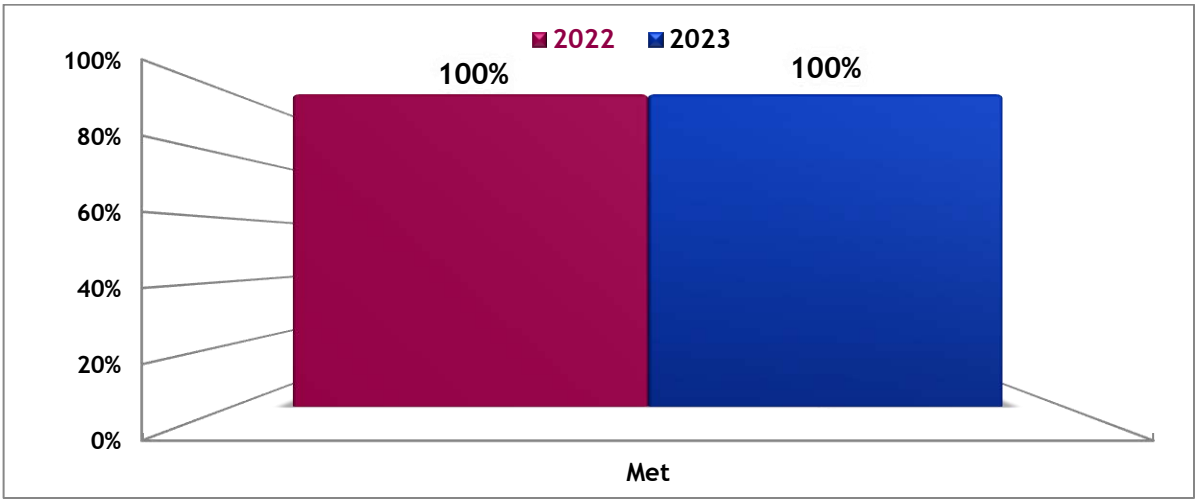
The written delegation agreements include the South Carolina Subcontractor Boilerplate and the SC Medicaid Delegation Services Addendum documents. These documents define applicable terminology and provide information about administrative requirements, laws, delegate obligations, records, auditing and oversight, safeguarding information, member billing, payment, and sub-delegation. The delegation agreements are specific to the activities being delegated to each entity and include information about consequences of substandard or noncompliant performance.

Corporate Delegation Compliance staff conduct annual delegation audits of policies, procedures, and other program documentation, any sub-delegation agreements, entity accreditations, file audits, etc. Standardized audit tools are used for the annual oversight activities. At completion of the annual audit, a score is determined. Any follow-up activities are initiated when the scores are below established thresholds and may include referral to appropriate committees and leadership, corrective actions, termination of delegation, etc. In addition to annual audits, ongoing monitoring is conducted through periodic delegate reporting and meetings.

Oversight documentation submitted for review confirmed timely annual oversight for all applicable delegates as well as routine reporting and meetings for all delegates. Annual oversight documentation reflected issuance of appropriate recommendations and corrective actions as needed, and follow-up of corrective actions.

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

Figure 8: Delegation Findings



Strengths

- Policies thoroughly document processes for pre-delegation assessments, approval of delegation, monitoring, and annual delegation oversight.
- Oversight documentation submitted for review confirmed timely annual oversight for all applicable delegates, and routine reporting and meetings for all delegates.
- Annual oversight documentation reflected issuance of appropriate recommendations and corrective actions as needed, and follow-up of corrective actions.

G. State Mandated Services

42 CFR Part 441, Subpart B

The review of State Mandated Services includes processes to track provider compliance with administering required immunizations and providing EPSDT/Well-Care services, health plan provision of member benefits, and the degree to which the health plan addressed previously identified deficiencies.

Policy SC.QLT.005, Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), lists EPSDT services and describes member education processes related to EPSDT services. The policy states that Humana identifies members who have gaps in care by running a report for member outreach. The policy also addresses provider education about EPSDT services through the Provider Manual and newsletters. Education includes relevant quality performance measures related to EPSDT services. Provider performance is monitored and tracked through population health dashboards and UM reporting. Performance metrics are presented and reviewed in the QAC annually.

Onsite discussion revealed that claims and encounter data are used to develop the dashboards and the Stars Quality Report. The dashboards are available to providers via secured login and present member-specific gaps.

Table 33: Previous State Mandated Services QIP Items includes the issues that were identified during the previous EQR related to tracking provider compliance with immunization administration and provision of EPSDT/Well-Child services and Humana's response. The current EQR confirmed the deficiencies were appropriately addressed.

Table 33: Previous State Mandated Services QIP Items

Standard	EQR Comments
V I I. STATE-MANDATED SERVICES	
1. The MCO tracks provider compliance with: 1.1 administering required immunizations;	Humana presented no evidence that it is currently tracking provider compliance with administering required immunizations. *Quality Improvement Plan: Implement activities to track provider compliance with administering required immunizations.*
Humana's Response: Humana tracks required immunization compliance with providers through various population health dashboards managed by key stakeholders within Humana. The dashboards allow for targeted compliance monitoring as well as education opportunities for the providers including reporting.	
1.2 performing EPSDTs/Well Care.	Humana presented no evidence that it is currently tracking provider compliance with performing EPSDT/Well Care services. Additionally, the *SCDHHS Contract, Section 4.2.10.1* states MCOs must "Have written Policies and Procedures consistent with *42 CFR 441, Subpart B*, for notification, tracking, and follow-up to ensure EPSDT services will be available to all Eligible Medicaid Managed Care Program children and young adults." *Quality Improvement Plan: Develop a written policy and procedure for notification, tracking, and follow-up to ensure EPSDT services are available to all eligible members. Implement activities to track provider compliance with performing EPSDT/well care services for members.*
Humana's Response: Humana has an active ESPDT policy in place outlining the health plan's EPSDT process for tracking, monitoring, and education process for both members and providers. Provider Compliance is tracked through population health dashboards that include HEDIS metric compliance monitoring.	

During the previous EQR, 16 standards were scored as "Partially Met" and eight standards were scored as "Not Met." Following the 2022 EQR, Humana submitted a Quality Improvement Plan to address the deficiencies. CCME reviewed and accepted the Quality Improvement Plan on June 28, 2022. During the current EQR, CCME assessed the degree

to which Humana implemented the actions to address these deficiencies and found the Quality Improvement Plans were not implemented for the previously identified deficiencies related to:

- References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana has confirmed in both 2022 and 2023 that this checklist is not used.
- Lack of a variety of participating network providers as members of the committee responsible for the Quality Improvement activities. Humana's Quality Assurance Committee did not contain a variety of participating network providers. For this EQR, one network practitioner and one physician consultant not participating in Humana's network had been added.
- Several appeal resolution letters did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letters stated, "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." Additionally, in several appeal resolution letters the verbiage used to describe why the denial was upheld appeared to be above the 6th grade reading level.

During last year's EQR, Humana was also noted to have uncorrected deficiencies from the previous EQR. See *Table 34: Previous State Mandated Services QIP Items*, for those previously uncorrected deficiencies and Humana's response.

Table 34: Previous State Mandated Services QIP Items

Standard	EQR Comments
V I I. STATE-MANDATED SERVICES	
3. The MCO addresses deficiencies identified in previous independent external quality reviews.	Humana did not implement the Quality Improvement Plans corrections to address the following deficiencies identified during the 2021 Readiness Review: •Action was not taken to ensure credentialing and recredentialing files include full collaborative agreements between nurse practitioners and their supervising/collaborating physician. •Action was not taken to ensure letters notifying providers of credentialing and recredentialing determinations are dated on or after the date of the credentialing/recredentialing determination. •There was not a specific policy or action steps planned for addressing the monitoring of over- and under-utilization.

Standard	EQR Comments
	Quality Improvement Plan: Address and implement actions to correct all identified deficiencies.
Humana's Response: Humana re-trained associates on 4/26/2022 to ensure collaborative agreements are included for nurse practitioners and their supervising/collaborating physician. Humana developed a new process that begins 5/12/2022 to better align credentialing and re-credentialing decisions and notification letter dates. Humana has developed a policy to address over and underutilization. Humana's Regulatory Compliance department will complete a pulse check in Q3 2022 on each newly implemented process.	

As noted in *Figure 9: State Mandated Services*, 75% of the standards in the State Mandated Services section of the review were scored as "Met."

Figure 9: State Mandated Services

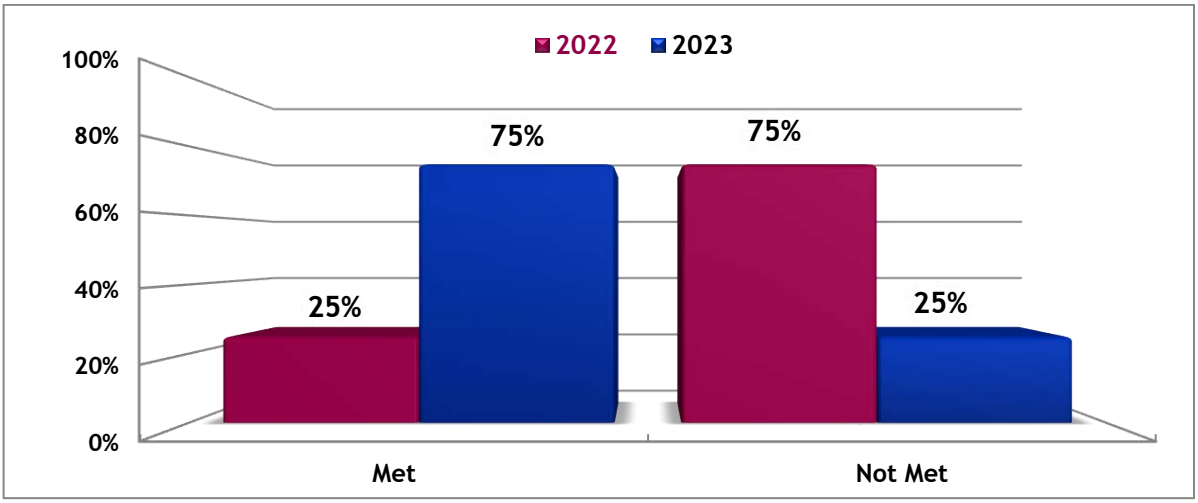


Table 35: State Mandated Services Comparative Data

SECTION	STANDARD	2022 REVIEW	2023 REVIEW
State-Mandated Services	The MCO tracks provider compliance with: Administering required immunizations	Not Met	Met
	Performing EPSDTs/Well Care	Not Met	Met

The standards reflected in the table are only the standards that showed a change in score from 2022 Review to 2023.

Strengths

- Humana has established processes to monitor and track provider compliance with provision of immunizations and EPSDT/Well-Care services.

Weaknesses

- During the current EQR, CCME assessed the degree to which the health plan implemented actions to address deficiencies from the previous EQR and found the Quality Improvement Plans were not implemented for the previously identified deficiencies related to:
  - References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana confirmed in both 2022 and 2023 that this checklist is not used.
  - Lack of a variety of participating network providers as members of the Quality Assurance Committee. For this EQR, one network practitioner and one physician consultant not participating in Humana's network had been added.
  - Appeal resolution letters not indicating that the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition, and use of verbiage in the appeal resolution letters that exceeds the 6th grade reading level.

Quality Improvement Plans

- Develop a plan of action to address and correct the deficiencies identified during this and previous EQRs. Include a monitoring component to ensure the plans are implemented timely and all deficiencies are corrected.

ATTACHMENTS

Attachment 1: Initial Notice, Materials Requested for Desk Review

Attachment 2: Materials Requested for Onsite Review

Attachment 3: EQR Validation Worksheets

Attachment 4: Tabular Spreadsheet

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

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

January 9, 2023

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

Dear Ms. Aresu:

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

The methodology used by CCME to conduct this review will follow the protocols developed by the Centers for Medicare and Medicaid Services (CMS) for external quality review of Medicaid Managed Care Organizations. As required by these protocols, the review will include both a desk review (at CCME), a virtual onsite visit and will address all contractually required services as well as follow up of any areas of weakness identified during the previous review. The two day virtual onsite will be conducted on **March 8th** and **9th**.

In preparation for the desk review, the items on the enclosed desk materials list should be provided to CCME no later than **January 23, 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 CCME thru the site. The file transfer site can be found at:

https://eqro.thecarolinascenter.org

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

Thank you and we look forward to working with you.

Sincerely,

Sandi Owens

Sandi Owens, LPN
Manager, External Quality Review

Enclosure
cc: SCDHHS

External Quality Review 2023

MATERIALS REQUESTED FOR DESK REVIEW

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

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

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

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

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

Excel Spreadsheet Format

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

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

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

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

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

10. The Quality Improvement work plans for 2022 and 2023.

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

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

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

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

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

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

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

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

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

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

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

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

23. A copy of the Grievance, Complaint and Appeal logs for the months of February 2022 through December 2022.

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

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

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

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

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

29. A copy of the provider handbook or manual.

30. A sample provider contract.

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

32. Provide a listing of all delegates conducting delegated activities. 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

33. Sample contract used for delegated entities. Include a sample contract for each type of service delegated, i.e., credentialing, behavioral health, utilization management, external review,

case/disease management, etc. Specific written agreements with subcontractors may be requested at the onsite review at CCME's discretion.

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

36. 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 February 2022 through December 2022. Include any medical information and physician review documentation used in making the denial determination.
    - d. Twenty-five utilization approval files (acute inpatient, outpatient, and behavioral health) for the months of February 2022 through December 2022, including any medical information and approval criteria used in the decision. Please include prior authorizations for surgery

and/or hospital admissions, concurrent stay, and retrospective review of admissions and of emergency care.

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

These materials:

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

B. Attachment 2: Materials Requested for Onsite Review

External Quality Review 2023

MATERIALS REQUESTED FOR ONSITE REVIEW

1. Copies of all committee minutes for committees that have met since the desk materials were submitted.
2. Credentials for all staff listed on the Org Chart.
3. The committee membership for the Clinical Practice Guidelines Physician Committee and the Quality Assurance Committee.
4. Attachment 3 (South Carolina Medicaid Specific Standards) of Policy SC.NNO.004, Provider Network Availability and Access.
5. A copy of the most recent Quest Analytics geographical analysis.
6. Policy or policies that address confidentiality.
7. Policy or policies that address appointment access call studies.
8. The following documents referenced in Section VIII (Resources) of Policy SC.NNO.007, Provider Orientation and Annual Training:
    a. Sample New Provider Orientation Checklist Market
    b. South Carolina Medicaid Annual Training Requirements
9. Policy or policies that address Quality of Care Referrals.
10. Humana's Corporate Clinical Practice Guidelines (CPG) policy and Evaluating CGP Adherence policy.
11. The "MCD-SC-QLT-Health Record Review Tool" referenced in Policy SC.QLT.007, Medical Record Review.
12. Provider contract used for primary care and specialty providers.

C. Attachment 3: EQR Validation Worksheets

CCME EQR PIP Validation Worksheet

PIHP Name:	**Humana**
Name of PIP:	**HPV VACCINE**
Reporting Year:	2022
Review Performed:	2023

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**	Data analysis and study rationale were reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim was reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addressed key aspects of enrollee care and service.
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**	PIP included all enrollees in relevant population.
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 was defined.
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators were related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources were documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data was collected from the HEDIS database.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
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**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
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 subsequent rates were presented.
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**	Analysis of data included rate evaluation by quarter.
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 reported.
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 report showed a rate of 1.82% in Q3, which was the MY 2021 final rate, and 3.85% in Q4, which is the interim MY 2022 rate. This is improvement toward the goal rate of 36.5% (goal change for NCQA from 38.44% to 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**	Interventions are improving vaccine rates.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough data to evaluate.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	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	NA	NA
9.4	NA	NA

Project Score	**79**
Project Possible Score	**79**
Validation Findings	**100%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PIP Validation Worksheet

PIHP Name:	**Humana**
Name of PIP:	**PRENATAL AND POSTPARTUM CARE**
Reporting Year:	2022
Review Performed:	2023

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**	Data analysis and study rationale were reported.
STEP 2: Review the PIP Aim Statement		
2.1 Was the statement of PIP Aim(s) appropriate and adequate? **(10)**	**MET**	Aim was reported.
STEP 3: Identified PIP population		
3.1 Does the PIP address a broad spectrum of key aspects of enrollee care and services? **(1)**	**MET**	Addressed key aspects of enrollee care and service.
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**	PIP included all enrollees in relevant population.
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**	Measures were defined (two indicators).
5.2 Did the indicators measure changes in health status, functional status, or enrollee satisfaction, or processes of care with strong associations with improved outcomes? **(1)**	**MET**	Indicators related to processes of care.
STEP 6: Review Data Collection Procedures		
6.1 Did the study design clearly specify the data to be collected? **(5)**	**MET**	Data collection methods were documented.
6.2 Did the study design clearly specify the sources of data? **(1)**	**MET**	Data sources were documented.
6.3 Did the study design specify a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply? **(1)**	**MET**	Data was collected from the HEDIS database.

Component / Standard (Total Points)	Score	Comments
6.4 Did the instruments for data collection provide for consistent, accurate data collection over the time periods studied? **(5)**	**MET**	Data collection instruments were documented.
6.5 Did the study design prospectively specify a data analysis plan? **(1)**	**MET**	Data analysis plan was included in the report.
6.6 Were qualified staff and personnel used to collect the data? **(5)**	**MET**	Staff for data collection and project analysis were documented.
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**	Rates were reported.
7.2 Did the MCO/PIHP present numerical PIP results and findings accurately and clearly? **(10)**	**MET**	Results were presented using tables.
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 subsequent rates were presented.
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**	Analysis of data included rate evaluation by quarter.
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 reported.
STEP 9: Assess the Likelihood that Significant and Sustained Improvement Occurred		
9.1 Was there any documented, quantitative improvement in processes or outcomes of care? **(1)**	**NOT MET**	Indicator 1 (timeliness of prenatal care) reduced from 100% to 84.49% with a goal of 85.40%. Indicator 2 (postpartum care) improved from 0% to 57.49% with a goal of 77.37%. ***Recommendation:*** *Initiate additional interventions to improve prenatal and postpartum care measures and continue to track interim progress as new interventions are implemented.*
9.2 Does the reported improvement in performance have "face" validity (i.e., does the improvement in performance appear to be the result of the planned quality improvement intervention)? **(5)**	**NA**	Improvement occurred for one indicator. Rates were unreliable due to small denominator. Validity was unable to be evaluated.
9.3 Is there any statistical evidence that any observed performance improvement is true improvement? **(1)**	**NA**	Statistical testing was not conducted; sampling not used.
9.4 Was sustained improvement demonstrated through repeated measurements over comparable time periods? **(5)**	**NA**	Not enough data to evaluate.

ACTIVITY 2: PERFORM OVERALL VALIDATION AND REPORTING OF PIP RESULTS

Steps	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	0	1
9.2	NA	NA
9.3	NA	NA
9.4	NA	NA

Project Score	**73**
Project Possible Score	**74**
Validation Findings	**99%**

AUDIT DESIGNATION
HIGH CONFIDENCE IN REPORTED RESULTS

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

CCME EQR PM Validation Worksheet

Plan Name:	**Humana**
Name of PM:	**ALL HEDIS MEASURES**
Reporting Year:	**2022**
Review Performed:	**2023**

SOURCE OF PERFORMANCE MEASURE SPECIFICATIONS
HEDIS TECHNICAL SPECIFICATIONS MY2021

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.
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.

NUMERATOR ELEMENTS			
Audit Elements	**Audit Specifications**	**Validation**	**Comments**
N2 Numerator	Calculation of the performance measure numerator adhered to all numerator specifications of the performance measure (e.g., member ID, age, sex, continuous enrollment calculation, clinical codes such as ICD-9, CPT-4, DSM-IV, member months' calculation, member years' calculation, and adherence to specified time parameters).	**Met**	Calculation of rates adhered to numerator specifications.
N3 Numerator–Medical Record Abstraction Only	If medical record abstraction was used, documentation/tools were adequate.	**Met**	Documentation and tools were found to be compliant.
N4 Numerator–Hybrid Only	If the hybrid method was used, the integration of administrative and medical record data was adequate.	**Met**	Integration methods were found to be compliant.
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 from Cotiviti. 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.

CCME EQR Survey Validation Worksheet

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

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. (updated based on October 2019 version of EQR protocol 6)

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*: SPH Analytics Member Satisfaction Report- Adult 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

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:* SPH Analytics Member Satisfaction Report- Adult 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

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:* SPH Analytics Member Satisfaction Report-Adult 2022
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:* SPH Analytics Member Satisfaction Report-Adult 2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
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:* SPH Analytics Member Satisfaction Report-Adult 2022
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:* SPH Analytics Member Satisfaction Report-Adult 2022

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:* SPH Analytics Member Satisfaction Report-Adult 2022
4.2	Assess the response rate, potential sources of non-response and bias, and implications of the response rate for the generalizability of survey findings.	**MET**	Response rate is reported and bias in generalizability is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Adult 2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* S PH Analytics Member Satisfaction Report-Adult 2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

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:* SPH Analytics Member Satisfaction Report- Adult 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022

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:* SPH Analytics Member Satisfaction Report- Adult 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The adult survey showed a response rate of 5.1% (10 out of 198 surveys). *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022.
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Adult 2022
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:* SPH Analytics Member Satisfaction Report- Adult 2022

CCME EQR Survey Validation Worksheet

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

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. (updated based on October 2019 version of EQR protocol 6)

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:* SPH Analytics Member Satisfaction Report- Child 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

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:* SPH Analytics Member Satisfaction Report- Child 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* S PH Analytics Member Satisfaction Report- Child 2022

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 identified. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
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:* SPH Analytics Member Satisfaction Report-Child 2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
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:* SPH Analytics Member Satisfaction Report-Child 2022
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:* SPH Analytics Member Satisfaction Report-Child 2022

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:* SPH Analytics Member Satisfaction Report-Child 2022
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:* SPH Analytics Member Satisfaction Report-Child 2022

ACTIVITY 5: REVIEW THE QUALITY ASSURANCE PLAN

Survey Element		Element Met / Not Met	Comments and Documentation
5.1	Was a quality assurance plan(s) in place that cover the following items: administration of the survey, receipt of data, respondent information and assistance, coding, editing and entering of data, procedures for missing data, and data that fails edits	**MET**	The quality plan is documented. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child 2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

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:* SPH Analytics Member Satisfaction Report- Child 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022

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:* SPH Analytics Member Satisfaction Report- Child 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The child survey showed a response rate of 7.9% with 9 out of 114 completed. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child 2022
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:* SPH Analytics Member Satisfaction Report- Child 2022

CCME EQR Survey Validation Worksheet

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

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. (updated based on October 2019 version of EQR protocol 6)

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:* SPH Analytics Member Satisfaction Report- Child CCC 2022
1.2	Review that the study objectives are clear, measurable, and in writing.	**MET**	Study objective documented in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
1.3	Review that the intended use or audience(s) for the survey findings are identified.	**MET**	Survey audience identified in the report. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

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:* SPH Analytics Member Satisfaction Report- Child CCC 2022
2.2	Assess whether the survey instrument was tested for reliability and found to be reliable	**MET**	Survey tested for reliability. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

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:* SPH Analytics Member Satisfaction Report-Child CCC 2022
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:* SPH Analytics Member Satisfaction Report-Child CCC 2022
3.3	Review that the sampling method appropriate to the survey purpose	**MET**	Sampling method was conducted according to specifications. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
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:* SPH Analytics Member Satisfaction Report-Child CCC 2022
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:* SPH Analytics Member Satisfaction Report-Child CCC 2022

ACTIVITY 4: REVIEW THE ADEQUACY OF THE RESPONSE RATE

Survey Element		Element Met / Not Met	Comments and Documentation
4.1	Review the specifications for calculating response rates to make sure they are in accordance with industry standards	**MET**	The specifications for response rates are in accordance with standards. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022
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:* SPH Analytics Member Satisfaction Report-Child CCC 2022

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:* SPH Analytics Member Satisfaction Report-Child CCC 2022
5.2	Did the implementation of the survey follow the planned approach?	**MET**	Survey implementation followed the plan. *Documentation:* SPH Analytics Member Satisfaction Report-Child CCC 2022

Survey Element		Element Met / Not Met	Comments and Documentation
5.3	Were procedures developed to handle treatment of missing data or data determined to be unusable?	**MET**	Procedures for missing data were developed and applied. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

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:* SPH Analytics Member Satisfaction Report- Child CCC 2022
6.2	Were appropriate statistical tests used and applied correctly?	**MET**	Appropriate tests were utilized. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
6.3	Were all survey conclusions supported by the data and analysis?	**MET**	Conclusions were supported by data analysis. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022

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:* SPH Analytics Member Satisfaction Report- Child CCC 2022
7.2	Do the survey findings have any limitations or problems with generalization of the results?	The Child CCC survey showed a response rate of 5.4% (4 out of 74 surveys). *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
7.4	What data analyzed according to the analysis plan laid out in the work plan?	Data was analyzed according to work plan. *Documentation:* SPH Analytics Member Satisfaction Report- Child CCC 2022
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:* SPH Analytics Member Satisfaction Report- Child CCC 2022

D. Attachment 4: Tabular Spreadsheet

The Carolinas Center *for* Medical Excellence

CCME MCO Data Collection Tool

Plan Name:	Humana Healthy Horizons in SC
Collection Date:	2023

I. ADMINISTRATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
I. ADMINISTRATION						
I A. General Approach to Policies and Procedures						
1. The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly.		X				Humana's general approach to policies and procedures has been revised as a result of the Quality Improvement Plan for the 2022 EQR. The 2023 EQR and corresponding onsite discussion confirmed that 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. Information about policy changes is shared with staff by leadership from each department, and staff may access policies via Humana's Enterprise Solution Point system.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Despite these changes, CCME noted continued issues with health plan policies, including: • Humana provided several versions of its Policy Index. The first index provided listed approximately 156 policies and the second index 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 for review included policies that did not specify a policy number and/or business owner. • Some policies were provided in a draft format. Examples include Policy QM-288-08, Provider Quality Review Process (draft watermark with a last review date of 1/27/22); Enterprise-Wide Policy #5051331 – Procedure - Government Programs PCP Request for Member Transfer_DRAFT (draft watermark with a last review date of 9/8/22); and Policy (Preauthorization List (PAL) Governance)-001 (draft watermark with issue date of 2/25/22). • Some policies did not provide a policy number within the document, although the document file name listed a number. Examples include the document labeled as "SC.MCC.008," "SC.CDT.001," and "SC.FIN.003."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: • *Revise the Policy Index to include all policies followed for conducting health plan activities and functions within SC.* • *Update the Policy Index to provide a policy number and business owner for each policy listed.* • *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.* • *Consider adding the most recent policy review date for each policy listed on the Policy Index.*
I B. Organizational Chart / Staffing						
1. The MCO's resources are sufficient to ensure that all health care products and services required by the State of South Carolina are provided to members. At a minimum, this includes designated staff performing in the following roles:						
1.1 *Administrator (Chief Executive Officer (CEO), Chief Operations Officer (COO), Executive Director (ED));			X			The *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."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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. • 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.*
1.2 Chief Financial Officer (CFO);	X					The Chief Financial Officer is Craig Stokan.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.3 * Contract Account Manager;	X					Taffney Hooks, Compliance Lead, is located in South Carolina and serves as the Contract Account Manager. Per onsite discussion, Ms. Hooks fulfills the role required by the *SCDHHS Contract, Section 2* which states, "The Contract Account Manager serves as the primary point-of-contact between the CONTRACTOR and the Department. The primary functions of the Contract Account Manager may include but are not limited to coordinating the tracking and submission of all contract deliverables; field and coordinate responses to the Department inquiries, and coordinate the preparation and execution of contract requirements such as random and periodic audits and ad hoc visits."
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 Director of Health Services.
1.5.1 Pharmacy Director,	X					Melissa Perraut is the Pharmacy Director.
1.5.2 Utilization Review Staff,	X					
1.5.3 *Case Management Staff,	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 *Quality Improvement (Coordinator, Manager, Director);	X					Ashley Franciscus is the Quality Assessment & Improvement Lead.
1.6.1 Quality Assessment and Performance Improvement Staff,	X					
1.7 *Provider Services Manager;			X			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.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• 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. *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.*
1.7.1 *Provider Services Staff,	X					
1.8 *Member Services Manager;			X			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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						visit 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.*
1.8.1 Member Services Staff,	X					
1.9 *Medical Director;	X					Dr. Ayo Gathing serves as Humana's Medical Director. The Medical Director is required to be located in SC per the *SCDHHS Contract*. The SC Credentialing Committee Membership list listed Dr. Gathing's mailing address as Atlanta Georgia. During the onsite, Dr. Gathing mentioned she had recently relocated to Lake Whylie SC. *Recommendation: Correct the address for the Medical Director on the Credentialing Committee Membership list and other contact lists.*
1.10 *Compliance Officer;	X					Regina Moore is the Compliance Officer.
1.10.1 *Program Integrity Coordinator;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10.2 Compliance/ Program Integrity Staff;	X					
1.11 * Interagency Liaison;	X					The *SCDHHS Contract, Section 2,* requires the Contractor to have "an Interagency Liaison who shall be responsible for coordinating the provision of services with HCBS waivers, community resources, the Department and other State agencies, and any other community entity that traditionally provides services for Medicaid Managed Care Members." Tawana Barksdale, Senior Compliance Specialist, fulfills the role of Interagency Liaison. During the onsite discussion, Ms. Barksdale confirmed she is located in South Carolina. Ms. Barksdale was not reported to SCDHHS as the Interagency Liaison. *Recommendation: Include the responsibilities for the Interagency Liaison in the job description for the employee serving in this role.*
1.12 Legal Staff;	X					Andrew Murr is Humana's legal representative.
1.13 *Behavioral Health Director;	X					Lindsay Johnson is the Behavioral Health Director.
1.14 *Program Integrity FWA Investigative/Review Staff.	X					David Posey oversees the Special Investigations Unit (SIU) program with two FWA staff located in South Carolina.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2. Operational relationships of MCO staff are clearly delineated.		X				The Organizational Chart provided by Humana 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. *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.*
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					SCDHHS requires MCOs to pay at least 90% of all clean claims within 30 days and to pay at least 99% of clean claims within 90 days of receipt. Humana's ISCA documentation notes that claim processing goals are set to meet or exceed these contractual obligations.
2. The MCO is capable of accepting and generating HIPAA compliant electronic transactions.	X					Humana currently processes 99% of incoming claims electronically, and the MCO uses HIPAA

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						compliant formats (X12-837) and National Council for Prescription Drug Programs (NCPDP). Additionally, Humana uses standards-based claims and encounter forms.
3. The MCO tracks enrollment and demographic data and links it to the provider base.	X					Humana collects member enrollment and demographic data and stores it in a database. Additionally, the MCO collects provider demographic data, which it leverages to populate an online provider directory.
4. The MCO's management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities.	X					Humana's systems are capable of generating internal reports and HEDIS reports for the State. Specifically, Humana uses NCQA certified software and vendors for its reporting needs. Humana audits its reporting logic and procedures yearly.
5. The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract.	X					Humana has implemented a layered approach to data security. The MCO has security controls deployed at the application, database, network, storage, and operating system layers to prevent unauthorized data access or inadvertent disclosure.
6. The MCO has policies, procedures and/or processes in place for addressing system and information security and access management.	X					Information and access management policies and procedures adhere to industry best practices. Additionally, Humana has established routines to verify security controls are functioning as expected. Humana also has an employee cybersecurity training program and regularly communicates with staff to remind them of potential threats.

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 has a detailed backup and disaster recovery (DR) plan. The plan incorporates multiple recovery options (DR site, cloud, remote datacenters). The DR plan is tested at least once per year.
I D. Compliance/Program Integrity						
1. The MCO has a Compliance Plan to guard against fraud and abuse.	X					Humana's Corporate Compliance Plan outlines the goals and scope of the plan and provides information about activities to "identify and address foreseeable risks, promptly respond to new legal or regulatory exposures, and achieve business objectives in an appropriate manner."
2. The Compliance Plan and/or policies and procedures address requirements, including:	X					
2.1 Standards of conduct;						Humana's Code of Conduct is entitled Ethics Every Day. It is provided to new employees and included in the annual training, thereafter. Information about standards of conduct is also included in the Corporate Compliance Plan.
2.2 Identification of the Compliance Officer and Program Integrity Coordinator;						The Compliance Officer is identified in Humana's Organizational Chart and, along with the Compliance Committee, is responsible for the high-level oversight of the Compliance Program. The Corporate Compliance Plan also identifies the roles and responsibilities of Compliance Officers and Compliance Committees.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.3 Inclusion of an organization chart identifying names and titles of all key staff;						
2.4 Information about the Compliance Committee;						
2.5 Compliance training and education;						Training and education are outlined in Humana's Ethics and Compliance Training and in the Compliance Plan. Training topics and oversight processes are included.
2.6 Lines of communication;						Multiple lines of communication are outlined for education, information, questions, and reporting of Compliance concerns as well as fraud, waste, and abuse.
2.7 Enforcement and accessibility;						
2.8 Internal monitoring and auditing;						Internal monitoring and auditing, along with risk-based assessments, are conducted to aid in the identification of compliance and FWA risks.
2.9 Response to offenses and corrective action;						The Special Investigations Unit (SIU), Agent Investigation Unit (AIU), and other teams work together to conduct timely investigations of potential compliance and/or FWA issues, which allows prompt action to be taken to correct any confirmed issues and mitigate the risk for recurrence.
2.10 Data mining, analysis, and reporting;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.11 Exclusion status monitoring.						Processes for exclusion status monitoring are addressed in the Compliance Plan and in related policies.
3. The MCO has an established committee responsible for oversight of the Compliance Program.	X					
4. The MCO's policies and procedures define processes to prevent and detect potential or suspected fraud, waste, and abuse.	X					
5. The MCO's policies and procedures define how investigations of all reported incidents are conducted.	X					
6. The MCO has processes in place for provider payment suspensions and recoupments of overpayments.	X					
7. The MCO implements and maintains a statewide Pharmacy Lock-In Program (SPLIP).	X					Policy SC.RX.004, Pharmacy Lock in Program, describes procedures for identifying members for inclusion in the Pharmacy Lock in Program. Members in the program are restricted to one pharmacy and are notified in writing of inclusion in the program and related instructions prior to the effective date of the restriction. Members may request to be assigned to a different pharmacy within 20 days of the date of the notification letter. Members may also appeal the restriction to the Pharmacy Lock-in Program within 30 days from receipt of the notification letter. The timeframe for the pharmacy restriction is 24 months; however, overrides are allowed under specific circumstances.
I E. Confidentiality *42 CFR § 438.224*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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's Compliance Plan, as well as policies, procedures, Program Descriptions, the Code of Conduct, etc. provide guidance about requirements for maintaining the confidentiality of Protected Health Information to ensure compliance with State and Federal laws and regulations.

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 2022 Healthy Horizons in South Carolina CORE Credentialing & Recredentialing Program Description (Credentialing Program Description) includes an overview of the Credentialing Program. Policy SC.CDT.001, Credentialing, Recredentialing, and Ongoing Sanction

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Monitoring, defines credentialing and recredentialing processes and requirements.
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 Policy SC.CDT.001 and in the Credentialing Program Description, Humana's Credentials Committee meets monthly and uses a peer review process to make recommendations for all credentialing and recredentialing decisions. Humana's SC Medical Director is the Credentials Committee Chairperson and votes only in the event of a tie. The Program Description and the 2022 South Carolina Medicaid Credentials Committee Charter define voting membership of the committee. CCME confirmed the voting membership of the Credentials Committee includes practitioners with specialties of Family Medicine, Obstetrics and Gynecology, and Psychiatry, as well as a Pharmacist and a Nurse Practitioner. The committee membership includes the practitioner types listed in the committee charter; however, this committee lacks a variety of specialists such as internal medicine, general surgery, neurology, etc.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Consider revising the Credentials Committee charter to require additional adult medicine specialists for committee membership and recruit a variety of specialty practitioners.
3. The credentialing process includes all elements required by the contract and by the MCO's internal policies.	X					The sample of initial credentialing files for practitioners reflected full compliance with initial credentialing requirements.
3.1 Verification of information on the applicant, including:						
3.1.1 Current valid license to practice in each state where the practitioner will treat members;	X					
3.1.2 Valid DEA certificate and/or CDS certificate;	X					
3.1.3 Professional education and training, or board certification if claimed by the applicant;	X					
3.1.4 Work history;	X					
3.1.5 Malpractice claims history;	X					
3.1.6 Formal application with attestation statement;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3.1.7 Query of the National Practitioner Data Bank (NPDB);	X					
3.1.8 Query of System for Award Management (SAM);	X					
3.1.9 Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
3.1.10 Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
3.1.11 Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE);	X					
3.1.12 Query of Social Security Administration's Death Master File (SSDMF);	X					
3.1.13 Query of the National Plan and Provider Enumeration System (NPPES);	X					
3.1.14 In good standing at the hospital designated by the provider as the primary admitting facility;	X					
3.1.15 Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					The sample of recredentialing files for practitioners reflects full compliance with recredentialing requirements.
4.1 Recredentialing conducted at least every 36 months;	X					
4.2 Verification of information on the applicant, including:						
4.2.1 Current valid license to practice in each state where the practitioner will treat members;	X					
4.2.2 Valid DEA certificate and/or CDS certificate;	X					
4.2.3 Board certification if claimed by the applicant;	X					
4.2.4 Malpractice claims since the previous credentialing event;	X					
4.2.5 Practitioner attestation statement;	X					
4.2.6 Requery the National Practitioner Data Bank (NPDB);	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
4.2.7 Requery of System for Award Management (SAM);	X					
4.2.8 Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline);	X					
4.2.9 Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause List;	X					
4.2.10 Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE);	X					
4.2.11 Query of the Social Security Administration's Death Master File (SSDMF);	X					
4.2.12 Query of the National Plan and Provider Enumeration System (NPPES);	X					
4.2.13 In good standing at the hospitals designated by the provider as the primary admitting facility;	X					
4.2.14 Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures;	X					
4.3 Review of practitioner profiling activities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 indicates Humana may take action to limit, reduce, restrict, suspend, revoke, or terminate a practitioner's network participation for quality-related reasons. Policy QM-288-08, Provider Quality Review Process, provided by Humana after the onsite visit, describes the process followed for terminating a provider for quality of care or service issues. As noted in the policy, the health plan's Medical Director, with assistance from the Quality Operations Compliance Department, conducts initial fact-finding activities and submits a summary of the quality issues as well as relevant records to the Peer Review Committee (PRC). The PRC conducts an evaluation and makes a recommendation for action. Providers are notified and offered the opportunity for a hearing. If a hearing is requested, the hearing panel completes a written report with recommendations that is provided to the PRC. The PRC Committee in turn makes a recommendation to the Corporate Recommendation Review Committee for a final decision.
6. Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
7. Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds.	X					The 2022 Credentialing Program Description addresses conducting monthly monitoring for provider sanctions, exclusions, limitations, and adverse actions between credentialing cycles and implementing corrective action as appropriate. Policy SC.ETC.001, Ineligible Persons / Entities Screening Requirements, describes the process for routine monitoring for provider sanctions and exclusions, and 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 maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements.						
1.1 Members have a primary care physician located within a 30-mile radius of their residence.	X					The Network Development Plan 2023 and Attachment #3 (South Carolina Medicaid Specific Standards) of Policy SC.NNO.004, Provider Network Availability and Access, appropriately define the geographic access standard for primary care providers (PCPs).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						The South Carolina Medicaid Network Adequacy Report (Updated December 7 with data as of December 6) includes primary care and pediatrics providers and lists the correct time/distance parameters for PCPs. County-by-county access is documented. This document indicates no network gaps were identified for primary care and pediatrics providers across all counties in the network. The SC_Medicaid_Ratio_2022December_Final document displays the both the number of members and number of providers of each type for each SC county.
1.2 Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty.	X					Attachment #3 (South Carolina Medicaid Specific Standards) of Policy SC.NNO.004, Provider Network Availability and Access, appropriately documents geographic access standards for specialty providers and hospitals. The South Carolina Medicaid Network Adequacy Report (Updated December 7 with data as of December 6) shows that Humana's network includes all required Status 1 provider types. The report indicates gaps for Hematology/Oncology (Aiken and Barnwell Counties) and Occupational Therapy (Allendale County).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Onsite discussion revealed that Humana is in negotiations with three Hematology/Oncology providers to address the gaps for Aiken and Barnwell Counties, and the gap for Occupational Therapy in Allendale County has been closed.
1.3 The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually.	X					During onsite discussion of Humana's processes for monitoring and assessing provider network adequacy, Humana staff reported that geographic access maps are not created; however, the health plan uses Power BI and other data analytics tools to generate reports so that any gaps in the geographic adequacy of the network can be identified. Per Humana staff, these reports are generated five times each month. Policy SC.NNO.004, Provider Network Availability and Access, states Humana uses current state or Medicaid requirements for the time and distance measurements and analyzes the network against the standards to evaluate the geographic distribution of each provider type at least quarterly.
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 2022 Healthy Horizons in South Carolina Quality Assessment and Performance Improvement Program Description addresses Culturally and Linguistically Appropriate Services (CLAS) and covers Humana's activities

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						to eliminate inequalities, health disparities, and barriers. These activities include: • Collecting and validating member ethnicity and racial data. • Providing cultural competency education and resources for providers. • Providing employee education about cultural sensitivity and competency. • Ensuring member materials are available in appropriate formats, providing translations of materials and offering language translations, and use of assistive tools such as telecommunications device for the deaf services and braille translations. • Monitoring risk assessments to ensure that Humana is meeting member needs. In addition, Humana's Corporate Bold Goal population health initiative addresses social determinants of health and health-related social needs for members and communities. The Provider Manual includes an overview of Cultural Competency and explains the expectation that services are provided in a culturally competent manner, with language barriers removed and accommodation of members' ethnic, cultural, and social needs. A hyperlink to Humana's Cultural Competency

STANDARD	SCORE					COMMENTS
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						Plan is included in the Provider Manual. The Provider Manual also includes a hyperlink to provider training materials and instructs providers to contact Provider Services to request a paper copy of the Cultural Competency Plan.
1.5 The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand.	X					
2. The MCO maintains a provider directory that includes all requirements.		X				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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
3. Practitioner Accessibility *42 CFR § 438.206(c)(1), 42 CFR § 457.1230(a), 42 CFR § 457.1230(b)*						
3.1 The MCO formulates and ensures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements.	X					Attachment 3 of Policy SC.NNO.004 and the Provider Manual define appointment access standards. Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting, states "Provider network availability will be monitored using the standards as required by Humana's MCO Contract requirements and may include CAHPS Survey, Complaint Analysis, EQRO Survey and Mystery Shopper Survey results. The Provider Access and Attitude and Timely Access to Care Mystery Shopper policies and procedures will be utilized as a part of the network availability monitoring." The policy does not define the frequency for conducting the mystery shopper call studies.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Revise Policy NNO 702-066-00, Network Availability and Access Monitoring and Reporting, to indicate the frequency of conducting mystery shopper call studies. A document with the heading "Executive Summary Report to Humana Healthy Horizons in South Carolina Quality Assurance Committee Provider Access and Availability Study," dated September 2022, documents the results of the call study. Barriers identified in the report included "Incorrect provider demographic information and limited resources to continuously validate data." When discussing the meaning of "limited resources to continuously validate data," Humana staff were unable to provide a definitive explanation. The documented also listed interventions to address the barriers, but CCME could not identify an intervention related to "limited resources to continuously validate data." Humana provided a written explanation after the onsite that most network providers serve multiple lines of business, and that additional data validation activities are necessary for Medicaid-only providers. The response

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						described the validation process used last year for those providers by Provider Relations staff, and that Humana is recruiting for additional, market-based associates to continuously monitor and update provider data. Also, the "Executive Summary Report to Humana Healthy Horizons in South Carolina Quality Assurance Committee Provider Access and Availability Study" document indicated the 2022 call survey included a question for specialists pertaining to immediate/emergent care visits and that "It was later determined that this is not a contractual requirement. Therefore, the response was excluded from this report. The question will be excluded from future surveys." When discussing this during the onsite, CCME explained that the *SCDHHS Contract, Section 6.2.3.1.5.1* states, "For specialty referrals, provide for: Emergent visits immediately upon referral." Humana staff responded during the onsite that for the 2022 survey, the wording of the question related to emergent specialty visits was misleading and would be revised prior to future surveys.
3.2 The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results.	X					As part of the annual EQR process for Humana, a provider access study was performed focusing on primary care providers. A list of current providers was given to CCME by Humana, from

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						which a population of 2,174 unique PCPs was identified. A sample of 175 providers was randomly selected from this population for the Access Study. Attempts were made to contact these providers to ask a series of questions regarding the access that members have with the contracted providers. In reference to the results of the Telephone Provider Access Study conducted by CCME, calls were successfully answered 57% of the time (94 out of 166), which is an improvement over last year's rate of 55% when omitting calls answered by personal or general voicemail messaging services, although it was not a statistically significant improvement (p = .718). For those not answered successfully (n= 72 calls), 54 (75%) were because the provider was no longer an active PCP at that location. For the question "Do you accept Humana?" 72 out of 94 (77%) said that they do accept Humana. Of those 72, 48 (67%) providers were accepting new Medicaid patients; eight out of those 48 (17%) indicated they do have prescreening requirements. Of the eight providers with prescreen requirements, five (63%) required an application, one (12%) required a medical record review, and two (25%) required vaccine

STANDARD	SCORE					COMMENTS
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						records. Regarding routine appointment availability, an appointment within 30 calendar days was noted for 25 out of the 33 (75%) that could offer an appointment without more specific patient information to schedule the appointment.
II C. Provider Education *42 CFR § 438.414, 42 CFR § 457.1260*						
1. The MCO formulates and acts within policies and procedures related to initial education of providers.			X			Policy 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. An example is the statement, "When a new provider orientation is required and/or necessary (based on type of plan), or the provider has requested orientation, the contractor will initiate the orientation process as follows, normally within thirty (30) days of the date of the executed contract." 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

STANDARD	SCORE					COMMENTS
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						Carolina Medicaid Annual Training Requirements. In response to CCME's request for a copy of the New Provider Orientation Checklist used for South Carolina providers, Humana stated 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." This statement is confusing as this policy is labeled as a South Carolina policy per the policy number of SC.NNO.007. Also, the reference in the policy to the New Provider Orientation Checklist was an issue noted during the previous EQR. Humana staff explained the initial provider orientation process and stated that an initial welcome letter is sent followed by a welcome call within 30 days. Humana provides links to all provider resources and offers one-on-one training if the provider desires. CCME reviewed the Healthcare Provider Resource Guide which provides information about online self-service, online resources, the Availity Portal, claims, prior authorization information, and contact information. The 2022

STANDARD	SCORE					COMMENTS
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						Provider Manual and the health plan's website are additional resources for providers. *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.*
2. Initial provider education includes:						
2.1 MCO structure and health care programs;	X					The health plan's structure and programs are detailed in the Provider Manual, in the 2022 Provider Orientation and Training document, and on Humana's website.
2.2 Billing and reimbursement practices;	X					Provider billing and reimbursement processes and requirements are covered in the Provider Manual, in the 2022 Provider Orientation and Training document, and on Humana's website.
2.3 Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS;	X					The 2022 Provider Orientation and Training document provides an overview of covered benefits and addresses copayments, excluded services, and non-covered services. The Provider Manual details information about member benefits, coverage limitations, copayments, etc.
2.4 Procedure for referral to a specialist;	X					The Provider Manual specialist referrals and states referrals from the PCP are not required for members to see participating specialists and members can self-refer to any

STANDARD	SCORE					COMMENTS
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						participating provider as long as any applicable benefit limits have not been exhausted.
2.5 Accessibility standards, including 24/7 access;	X					
2.6 Recommended standards of care;	X					The Provider Manual includes information about Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, including examination frequency and information about immunizations. The Provider Manual includes information that Humana encourages the use of clinical practice and preventive health guidelines, and that the guidelines are available through the website and newsletters and by contacting Care Management or Provider Relations representatives.
2.7 Medical record handling, availability, retention and confidentiality;	X					
2.8 Provider and member grievance and appeal procedures;	X					
2.9 Pharmacy policies and procedures necessary for making informed prescription choices;	X					
2.10 Reassignment of a member to another PCP;		X				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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
2.11 Medical record documentation requirements.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures.	X					Policy SC.NNO.007, Provider Orientation and Annual Training, indicates ongoing education is provided through the Provider Manual, newsletters and other educational materials, the website, the Availity portal, and through face-to-face, and virtual education sessions/webinars, etc. Section VIII (Resources) of the policy lists the South Carolina Medicaid Annual Training Requirements which were not attached to the policy. Per written response from Humana, ongoing provider training includes: • Four annual regional provider training sessions. • Training about program changes through the Humana Healthy Horizons in South Carolina Orientation and Training module. • In-service office visits to educate, monitor performance, and assist with resolving issues. • Ad hoc provider site meetings and webinars. • Periodic provider newsletters, and mailings. • Annual compliance training. • Updates to the provider portal, Provider Manual, Provider Quick Reference Guide,

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Prescription Drug Guide, Quality resources, etc. Annual postcards are sent to remind providers to complete training or attest to completion of substantial similar training.
II D. Primary and Secondary Preventive Health Guidelines *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops preventive health guidelines that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated.	X					The Corporate Physicians Clinical Practice Guidelines Committee meets twice yearly to review existing, new, and revised guidelines. The committee makes recommendations regarding the guidelines, and final approval of the guidelines is the responsibility of the CQIC. The guidelines are communicated to the health plan for presentation to the plan's QAC annually. Membership of the Corporate Physicians Clinical Practice Guidelines Committee includes internal physicians from a cross section of disciplines, QOCA leaders or designees, and approximately three local market physicians. Humana confirmed that there are four external cross-specialty physicians on the committee, but that there are no South Carolina physician members of the

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						committee. The quorum is established as 50% plus one. *Recommendation: Include a South Carolina network physician as a member of the Corporate Physicians Clinical Practice Guidelines Committee.*
2. The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers.	X					The Provider Manual addresses clinical practice guidelines and states Humana encourages providers to use the guidelines as an assistive tool for making decisions about appropriate healthcare for specific circumstances and to promote positive outcomes. The manual indicates use of the guidelines allows Humana to measure the impact of the guidelines on care outcomes and informs that Humana monitors provider implementation of guidelines through claim, pharmacy, and utilization data. As noted in the Provider Manual, the guidelines are distributed through the health plan's website and are also available from Provider Relations Representatives and the Care Management Department. Updates are provided through newsletters, Provider Manual updates, and the website. CCME confirmed that the adopted guidelines are available on Humana's website.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. The preventive health guidelines include, at a minimum, the following if relevant to member demographics:						
3.1 Well child care at specified intervals, including EPSDTs at State-mandated intervals;	X					
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. Clinical Practice Guidelines for Disease, Chronic Illness Management, and Behavioral Health Services *42 CFR § 438.236, 42 CFR § 457.1233(a)*						
1. The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services that are consistent with national or professional standards and covered benefits, are	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists.						
2. The MCO communicates the clinical practice guidelines and the expectation that they will be followed for MCO members to providers.	X					
II F. Continuity of Care *42 CFR § 438.208, 42 CFR § 457.1230(c)*						
1. The MCO monitors continuity and coordination of care between PCPs and other providers.	X					The South Carolina Humana Healthy Horizons (Continuity and Coordination of Care) Policy states Humana monitors the coordination of care between providers by conducting medical record reviews, monitoring HEDIS and CAHPS data, disease/case management data, appeal/grievance data, member/provider satisfaction surveys, and other internal coordination activities (UM, pharmacy, etc.). The 2022 Quality Assessment and Performance Improvement (QAPI) Program Description also provides an overview of MCO processes for assessing continuity and coordination of medical care. The QAPI Program Description also indicates Humana collaborates with BH practitioners annually to monitor and improve coordination between medical and behavioral health care providers.
II G. Practitioner Medical Records						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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.007, Medical Record Review, describes Humana's medical record review process for assessing provider compliance with medical record documentation standards. The policy and the Provider Manual include the required medical record documentation elements. The policy does not define the frequency of medical record audits. Onsite discussion confirmed the audits are conducted quarterly. A Quality Compliance Nurse conducts the medical record audits and submits results to the Associate Director of Quality Improvement. Providers are given written notification of their results and physicians who fall below 85% are reaudited approximately 6 months after the initial audit. With the scoring notification letter, Humana may include the Medical Record Review criteria, other resources, and provider education for improving documentation practices. *Recommendation: Revise Policy SC.QLT.007, Medical Record Review, to indicate the frequency of conducting medical record audits.*
2. Standards for acceptable documentation in member medical records are consistent with contract requirements.	X					Required medical record documentation elements are appropriately documented in Policy SC.QLT.007 and in the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
3. Medical Record Audit						
3.1 The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers.	X					QAC Minutes from 11/15/22 indicate a Medical Record Documentation Review (MRDR) was conducted in Q2 2022. The overall compliance average was 76.3%. Identified barriers were related to incorrect provider group fax numbers, medical records not received, unreliable data due to low volume of charts, etc. Interventions were documented and included: • Provider education on medical record documentation elements. • Use of batch requests including additional criteria and instruction of information needed. • Revision of component weights and segregation of medical records by member age. • Update of the record review tool At the time of the current EQR, Humana reported a medical record audit was in process.
4. Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract.	X					

III. MEMBER SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
III. MEMBER SERVICES						
III A. Member Rights and Responsibilities *42 CFR § 438.100, 42 CFR § 457.1220*						
1. The MCO formulates and implements policies guaranteeing each member's rights and responsibilities and processes for informing members of their rights and responsibilities.	X					Policy SC.MKT.001, Marketing and Member Communication, states the new member Welcome Kit includes information about member rights and responsibilities. However, CCME was unable to locate a policy specifying member rights and responsibilities. A document with the file name of "SC_EN_Welcome_kit" instructs the reader to go to the Member Handbook on Humana's website to access a full list of member rights. *Recommendation: Develop and implement a policy that specifies the rights that are guaranteed to members as well as member responsibilities.*
2. Member rights include, but are not limited to, the right:	X					Member rights and responsibilities are listed in the Member Handbook, Provider Manual, and on Humana's website.
2.1 To be treated with respect and with due consideration for dignity and privacy;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand;						
2.3 To participate in decision-making regarding their health care, including the right to refuse treatment;						
2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with Federal regulations;						
2.5 To be able to request and receive a copy of the member's medical records and request that 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. The policy states that the Welcome Kit includes an

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						introduction to the health plan and provides information about benefits and services, MCO contact information, rights and responsibilities, Member Services functions, etc. New Members are also provided a copy of the Member Handbook and ID card within 14 calendar days of receipt of enrollment information.
1.1 Benefits and services included and excluded in coverage;						The Member Handbook includes a benefits grid and additional information about covered and excluded benefits and services. The Member Handbook does not indicate that non-hospital based rehabilitative therapies for children are covered and provided through the Local Education Authorities (LEA) or Private Rehabilitation Services programs. Refer to the *SCDHHS Contract, Section 4.2.22.* *Recommendation: Revise the Member Handbook to address coverage for non-hospital based rehabilitative therapies for children.*
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.						The Member Handbook informs that members may seek second opinions from any doctor in or out of Humana's network, and that prior

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						authorization is required when seeking prior approval from a nonparticipating provider.
1.2 How members may obtain benefits, including family planning services from out-of-network providers;						
1.3 Any applicable deductibles, copayments, limits of coverage, and maximum allowable benefits;						
1.4 Any requirements for prior approval of medical or behavioral health care and services;						
1.5 Procedures for and restrictions on obtaining out-of-network medical care;						
1.6 Procedures for and restrictions on 24-hour access to care, including elective, urgent, and emergency medical services, including post-stabilization services;						The Member Handbook provides information about seeking elective, urgent, and emergent care. The handbook also explains post-stabilization care.
1.7 Policies and procedures for accessing specialty care;						
1.8 Policies and procedures for obtaining prescription medications and medical equipment, including applicable restrictions;						Information about the Preferred Drug List, medication limitations, restrictions, and exclusions, copayment requirements, over the counter medications, etc. is included in the Member Handbook.
1.9 Policies and procedures for notifying members affected by changes in benefits, services, and/or the provider network;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.10 Procedures for selecting and changing a primary care provider and for using the PCP as the initial contact for care;						The Member Handbook indicates the criteria followed for assignment of new members to a PCP and instructs members to contact Member Services to change the assignment to another PCP. It also indicates members may check to see if a PCP is in-network by accessing the "Find a Doctor" tool on the website.
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;						Information about the Provider Directory is included in the Member Handbook. The handbook informs that a copy of the Provider Directory is available upon request and that members may access the most current version of the Provider Directory on the website and may contact member services to obtain information about providers.
1.14 Instructions on how to request interpretation and translation services at no cost to the member;						
1.15 Member's rights, responsibilities, and protections;						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.16 Description of the Medicaid card and the MCO's Member ID card, why both are necessary, and how to use them;						
1.17 A description of Member Services and the toll-free number, fax number, e-mail address and mailing address to contact Member Services;						
1.18 How to make, change, and cancel medical appointments and the importance of canceling and/or rescheduling appointments when necessary;						
1.19 Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services;						An overview of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services is included in the Member Handbook. The handbook lists the services included EPSDT and provides the periodicity schedule for EPSDT services from infancy through the month of the member's 21st birthday.
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;						The Member Handbook provides an explanation of fraud, waste, and abuse, and provides examples of each. The handbook provides a variety of options for anonymous reporting by telephone, in writing by mail or fax, and online

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						submission to Humana, and by telephone to the U.S. Office of Inspector General's Fraud Line.
1.22 Additional information as required by the contract and/or federal regulation;						
2. Members are notified at least once per year of their right to request a Member Handbook or Provider Directory.	X					
3. Members are informed in writing of changes in benefits and changes to the provider network.	X					
4. Member program education materials are written in a clear and understandable manner and meet contractual requirements.	X					
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					As noted in the Member Handbook and on Humana's website, the Nurse Advice Line is available 24 hours a day, 7 days a week, 365 days a year.
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, 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 "offer or attempt

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
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 an overview of Care Management and Outreach Services and informs members that they may request these services or be referred for the services by their

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						providers. Contact information is provided for Care Management Support Services so that members may request additional information and/or self-refer to the Care Management or Disease Management Programs. SC.QLT.005-Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), describes methods of educating members about preventive health services, including but not limited to, messaging campaigns, community education events, the Member Handbook, and welcome calls.
2. The MCO tracks children eligible for recommended EPSDT services/immunizations and encourages members to utilize these benefits.	X					SC.QLT.005-Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), describes processes for identifying members for whom services may be overdue so that outreach can be initiated to encourage members to obtain the recommended services.
3. The MCO provides education to members regarding health risk factors and wellness promotion.	X					
4. The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in recommended care.	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 SPH Analytics, a certified CAHPS survey vendor to conduct the adult and child surveys. This is the first year the CAHPS survey was administered for Humana. CAHPS surveys were conducted by SPH Analytics for MY2021 and RY2022. The adult survey showed a response rate of 5.1% (10 of 198 surveys). Adult rates were above quality compass 90th percentile for Getting Needed Care, Getting Care Quickly, Coordination of Care, and Advised to Quit Smoking. The child survey showed a response rate of 7.9% (9 of 114 completed). Child rates were above the 90th percentile for Rating of Specialist and Coordination of Care. The child CCC survey showed a response rate of 5.4% (4 of 74 surveys). Child CCC rates were above the 90th percentile for Getting Care Quickly.
1.1 Statistically sound methodology, including probability sampling to ensure it is representative of the total membership;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					SPH Analytics summarizes and details all results from the Adult, Child, and CCC surveys. Humana then analyzes the reports provided by SPH Analytics.
3. The MCO implements significant measures to address quality issues identified through the member satisfaction survey.	X					Humana's documentation provided evidence of the analysis, discussion, and implementation of initiatives to address problematic areas of member satisfaction.
4. The MCO reports the results of the member satisfaction survey to providers.	X					Per onsite discussion, since accreditation occurred after the initial CAHPS survey, the survey results will be reported to providers later this year via the Provider Newsletter.
5. The MCO reports results of the member satisfaction survey and the impact of measures taken to address identified quality issues to the Quality Improvement Committee.	X					Issues and action plans were noted in Quality Assurance Committee Meeting Minutes from August 2022.
III F. Grievances *42 CFR § 438. 228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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					Humana provided two policies addressing grievances: • Policy SC.GAA.001, Medicaid Grievances and Appeals • Policy SC.MCC.005, Member Grievance and Appeals Policy SC.MCC.005, Member Grievance and Appeals, is a Medicaid Member Call Center policy and defines the guidelines for handling grievance calls from members. As noted in the policy, call center staff will attempt to resolve the member's issue and will document it as a grievance. Policy SC.GAA.001, Medicaid Grievances and Appeals, is a Grievance and Appeals Resolution Team policy. This policy provides more detailed information about processes for handling grievances from receipt through resolution.
1.1 The definition of a grievance and who may file a grievance;		X				Policy SC.GAA.001 and page 10 of the Member Handbook define 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 the *SCDHHS Contract, Section 9* and *42 CFR 438.400 (b)*. It was noted that page 63 of the Member Handbook uses

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						appropriate verbiage when defining 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.*
1.2 Procedures for filing and handling a grievance;	X					
1.3 Timeliness guidelines for resolution of a grievance;	X					The grievance resolution timeframe is appropriately defined in Policy SC.GAA.001, the Member Handbook, and in the Provider Manual.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 Review of grievances related to clinical issues or denial of expedited appeal resolution by a Medical Director or a physician designee;	X					
1.5 Maintenance and retention of a grievance log and grievance records for the period specified in the contract.	X					
2. The MCO applies grievance policies and procedures as formulated.	X					A review of randomly selected grievance files found that the grievances were handled appropriately with no issues identified.
3. Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
4. Grievances are managed in accordance with the MCO confidentiality policies and procedures.	X					

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 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*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						structure related to the staff assigned to the QI Program and their responsibilities.
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					Humana's 2022 QI Program description included specific areas that encompass members, providers, and systems. Monitoring of potential inappropriate utilization of health services is included in the QI scope of work.
3. An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s).	X					Annually, Humana develops a work plan to track and manage specific activities to be undertaken during the year. The 2022 and 2023 Work Plans were submitted for review. These work plans included activities/tasks, objectives for each activity, responsible parties, and timeframes for completion. In the 2022 QI work plan, there were several goals that had not been determined. CCME recommended Humana determine the measurement goals for each activity. Humana completed that recommendation and included the specific goals for each activity where applicable.
IV B. Quality Improvement Committee						
1. The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities.	X					Humana's Internal Board/Management Team (Corporate) has ultimate responsibility for the QI Program and has delegated authority and oversight to the Corporate Quality Improvement Committee and the Quality Assurance Committee (QAC). The QAC is the local (SC) committee responsible for the operational

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						oversight for the QI activities within the SC Plan. Some of the responsibilities outlined in the QI Program description include ensure QI activities take place throughout the organization, review and evaluate results of the quality and population health activities, review provider network performance, and ensure providers are included in the QI Program. The QI Lead reports quarterly on behalf of the QAC to the Corporate Quality Improvement Committee and ultimately the Internal Board.
2. The composition of the QI Committee reflects the membership required by the contract.			X			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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
3. The QI Committee meets at regular quarterly intervals.	X					The QAC meets at least quarterly as demonstrated by the provided committee minutes. A quorum of voting members in attendance is necessary for committee action. Humana defines a quorum as 50% of the voting membership plus one. Voting members are expected to attend each meeting. In their absence, a proxy representative is required.
4. Minutes are maintained that document proceedings of the QI Committee.	X					Minutes for each meeting are maintained and clearly reflected the committee's decisions, actions and follow-up or next steps. Minutes are reviewed and approved at the next regularly scheduled meeting. The minutes for the QAC were provided for this EQR for meetings held from February 2022 through January 2023.
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 utilized Dunwoody Technology Services Group (DTS Group) as their HEDIS auditor. The audit report indicated Humana uses Cotiviti as the measure vendor. The report demonstrated full compliance with standards and

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						specifications. The MY 2021 audit review table with rates were provided for review. Due to low enrollment during this time period, several rates were not reported due to a zero denominator.
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					Humana submitted two PIPs for validation. Topics included HPV Vaccine and Prenatal and Postpartum Compliance.
2. The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects."	X					Both projects scored within the "High Confidence in Reported Results" range and met all the validation requirements. The PIP reports had some issues with how the documents were organized and contained a few typos. For the HPV vaccine PIP, the report showed a rate of 1.82% in Q3 which was the MY2021 final rate and 3.85% in Q4 which is the interim MY2022 rate. This was an improvement toward the goal rate of 36.5%. For the Prenatal and Postpartum Care PIP, the timeliness of prenatal care measure and postpartum care measures were examined. For the timeliness of prenatal care, the final MY2021 rate reported in Q3 was 100% (although the sample included only 3 women); the interim MY2022 rate was 84.49% (target rate is 85.4%).

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						This rate declined, although the denominator for baseline was very small therefore, the reliability of that rate is difficult to ascertain. For postpartum care measure, the baseline rate was 0%, which increased to 57.59% for the interim MY2022 rate. *Recommendation: Initiate additional interventions to improve prenatal and postpartum care measures and continue to track interim progress as new interventions are implemented. Review the PIP documentation and correct the typos. Consider revising the PIP documents to improve the organization of the information displayed in the documents.*
IV E. Provider Participation in Quality Improvement Activities						
1. The MCO requires its providers to actively participate in QI activities.	X					Humana informs providers via the Provider Manual and provider contract of the requirement to participate and comply with the organization's QI Program.
2. Providers receive interpretation of their QI performance data and feedback regarding QI activities.	X					Results of provider performance are shared through the Stars Quality Report. This report provides a list of members that have a known gap in care and is delivered to providers via in-person visits, self-service access to a provider reporting system, mail, and secure fax.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Primary care providers have the option to participate in the value-based program that allows providers to earn financial incentives based on quality and clinical outcomes. The value-based program is based on the provider's panel size and their engagement. Provider performance is reviewed, and value-based reimbursements are made annually.
IV F. Annual Evaluation of the Quality Improvement Program *42 CFR §438.330 (e)(2) and §457.1240 (b)*						
1. A written summary and assessment of the effectiveness of the QI program for the year is prepared annually.		X				Annually, 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)

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Delegation Oversight monitoring Also, the goal for measuring the credentialing and recredentialing activities appeared to be 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.*
2. The annual report of the QI program is submitted to the QI Committee and to the MCO Board of Directors.	X					

V. UTILIZATION MANAGEMENT

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V. Utilization Management						
V A. The Utilization Management (UM) Program						
1. The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to:		X				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 manager. However, page 15 of the UM Program Description and Humana's website list Humana Centerwell Pharmacy as the pharmacy benefit manager.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.
1.1 structure of the program and methodology used to evaluate the medical necessity;	X					UM Staff are composed of clinical associates (nurses or behavioral health professionals) responsible for conducting Level I medical necessity reviews. Non-clinical associates may receive and perform data entry of requests from providers and process authorization requests that do not require a clinical review.
1.2 lines of responsibility and accountability;	X					
1.3 guidelines / standards to be used in making utilization management decisions;		X				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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
1.4 timeliness of UM decisions, initial notification, and written (or electronic) verification;	X					
1.5 consideration of new technology;	X					The Technology Assessment Forum meets at least quarterly to determine Humana's current coverage decisions and evaluate new technology to be included within the benefit plan. Humana also involves practitioners in the annual review and approval of any clinical criteria.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.6 the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services;	X					
1.7 the mechanism to provide for a preferred provider program.	X					
2. Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee.	X					The responsibilities of the Chief Medical Officer are to provide oversight of the UM Program, conduct Level II Reviews, participate in peer-to-peer consultations, etc. The Pharmacy Director's responsibilities entail trend monitoring, peer-to-peer collaboration, formulary oversight, etc. The Health Services Director and Behavioral Health Director provide daily operational management of the UM Program.
3. The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions.	X					
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					Review staff are trained to use clinical decision support tools or various guidelines and evidence-based criteria to make medical necessity

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determinations. Those guidelines include Milliman Care Guidelines, American Society of Addition Medicine, SC Medicaid coverage manuals, and internal Medical Clinical Coverage policies. For pharmacy authorizations, reviewers use references such as American Hospital Formulary Service-Drug Information (AHFS-DI), National Comprehensive Cancer Network (NCCN) Drugs and Biologics, Compendium Truven Health Analytics Micromedex DrugDEX, Elsevier/Gold Standard Clinical Pharmacology, and Wolters Kluwer Lexi-Drugs.
2. Utilization management decisions are made using predetermined standards/criteria and all available medical information.	X					Review of the approval files reflected that UM reviewers used clinical criteria for making medical necessity determinations and the reviews were completed timely.
3. Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations.	X					The Clinical Claims Review Team is responsible for reviewing claims for abortions, hysterectomies, and sterilizations. The Provider Manual and website provide the guidelines for coverage of abortions, hysterectomies, and sterilizations.
4. Utilization management standards/criteria are reasonable and allow for unique individual patient decisions.	X					
5. Utilization management standards/criteria are consistently applied to all members across all reviewers.	X					Humana's UM Program Description provided a summary of the Inter-rater Reliability (IRR) monitoring process used to assess consistency in decision-making for all staff who render clinical

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						determinations. During onsite discussion, it was described that a validator is utilized to ensure the validity of the test. The results of the recent annual IRR testing were provided. The reviewer received a passing score of 95%. Also, Humana stated monthly case audits, weekly team meetings, and real time denial letter audits are conducted for quality assurance and training as needed for UM Reviewers.
6. Pharmacy Requirements						
6.1 Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts.	X					The Pharmacy Program Description provides an overview and structure of Humana's pharmacy program. The Preferred Drug List (PDL) identifies formulary restrictions by indicating medications requiring prior approval, limitations, and/or step therapy requirements. The Pharmacy and Therapeutics Committee is responsible for the review and decisions made regarding the PDL. English and Spanish versions of the PDL were found on Humana's website. Changes to the PDL are posted on the website. The change document included the date the notice was posted and the effective date for the change.
6.2 If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity.		X				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

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
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					UM Staff include clinical associates (nurses or behavioral health professionals) with an active license. During onsite discussion, Humana identified that they currently have six UM reviewers on staff, including five nurses and one behavioral health clinician.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
10. Initial utilization decisions are made promptly after all necessary information is received.	X					Review of the approval files reflect that determinations were completed within 14 calendar days for standard requests and 72 hours for urgent 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					The review of denial files revealed inconsistency in the timeframes allowed for providers to submit information when additional information was requested. The UM Program Description (page 10) indicates two attempts will be made to obtain additional information from the provider. Humana described this process during the onsite. It was mentioned that if a medical director receives a second level review with insufficient or no clinical information available, if a minimum of two attempts to obtain this information was made, and it has been at least one business day since the date of the request, the Medical Director will issue a denial. Some of the files lacked documentation of those two attempts, the timeframe the provider was given for submitting the additional information, and/or whether the additional information was received. *Recommendation: When additional information is needed to complete a request for prior authorization, document the attempts to reach the provider, the provider's response, and include the*

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						timeframe for submitting the additional information.
11.2 All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist.	X					All denial decisions were made by a physician.
11.3 Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal.	X					Humana provided several letter templates for notifying providers and members of adverse benefit determinations. During the 2022 EQR, CCME identified errors in the Notice of Denial and the Notice of Partial Denial letter templates. These errors included the timeframe for an extension and an incorrect address. Humana corrected these errors as evident by the letter templates submitted for this EQR. However, the old notices were found in some of the denial files reviewed. Humana explained the corrected letters were approved and implemented in May/June 2022. The incorrect letters identified in the files reviewed by CCME occurred before June 2022. *Recommendation: Ensure staff are provided and utilize the corrected Adverse Benefit Determination notices. Review and monitor all notices to ensure the correct notices are being utilized.*
V C. Appeals *42 CFR § 438.228, 42 CFR § 438, Subpart F, 42 CFR § 457. 1260*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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, the Provider Manual, and the Member Handbook outline Humana's appeals process. Humana's processes for handling standard and expedited appeal requests are included in the policy.
1.1 The definitions of an adverse benefit determination and an appeal and who may file an appeal;	X					
1.2 The procedure for filing an appeal;	X					The Provider Manual, Member Handbook, and Humana's website offer various methods 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. However, the instructions for filing an appeal are mentioned in the Grievance section (page 63) of the Member Handbook and not included in the Appeal Section. *Recommendation: Include the information regarding how a member can file an appeal online in the Appeal section of the Member Handbook.*
1.3 Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case;	X					

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1.4 A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay;	X					Policy SC.GAA.01, SC Medicaid Grievance and Appeal Policy, the Member Handbook, Provider Manual, and the health plan's website describe the expedited appeal process and indicate expedited appeals are completed within 72 hours.
1.5 Timeliness guidelines for resolution of the appeal as specified in the contract;	X					
1.6 Written notice of the appeal resolution as required by the contract;	X					
1.7 Other requirements as specified in the contract.	X					
2. The MCO applies the appeal policies and procedures as formulated.			X			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. • 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."

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						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.*
3. Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee.	X					
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)*						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
1. The MCO formulates policies and procedures that describe its care management/care coordination programs.	X					The Case Management Program Description and Policy SC.CLI.02, Continuity of Care and Care Transitions, provide a descriptive overview and approach of Humana's Care Management (CM) Program.
2. The MCO has processes to identify members who may benefit from care management.	X					Members and providers are informed of the CM Program and methods to access CM services through the website, Provider Manual, and Member Handbook. Members are referred for CM services through various resources. Referrals are accepted by fax, mail, email, and phone.
3. The MCO provides care management activities based on the member's risk stratification.	X					Humana indicated that the health plan does not currently have predictive modeling software to identify members for care management but plans to implement a predictive modeling tool by the end of the year. Hospital data, claims, direct referrals, etc. are utilized in the interim to identify members for potential care management.
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					
6. Care Transitions activities include all contractually required components.						

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
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 for members entering the health plan, pregnant, etc.
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					Humana conducts an annual evaluation to assess trends, monitor any key indicator of clinical outcomes for members etc. to evaluate strengths, weaknesses, and opportunities for improvement. The evaluation also includes the results of the members' satisfaction with CM services. The data is presented to the QAC for approval.
8. Care management and coordination activities are conducted as required.	X					Humana's CM files indicate CM activities are performed as required, including conducting assessments, treatment planning, follow up, and linkage to appropriate community resources. However, there was one file in which the member was engaged in CM and required an inpatient admission. The case was closed as unable to contact. During onsite discussion, Humana staff described the process for closing CM cases when care managers are unable to contact the member. According to Humana, two telephone attempts are made and a letter from Humana's care manager is sent within a two-week period before a member's case is closed. This process was not followed, as

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						the member's case was closed within one week of the first initiated telephone call. Also, in one file, the member was not informed of their right to opt in or out of the CM Program. Humana indicated this was not addressed for this member in error. *Recommendation: Develop a policy or include in the Care Management Program Description the process Humana uses when unable to contact members and that members are notified of their ability to opt in and out of care management program.*
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					Policy SC CLI 006, Over and Under Utilization Data Plan, offers procedures for utilization anomalies. Monthly data for admissions, length of stays, readmissions, ER visits, and urgent care visits were submitted. The results, as of October 2022, showed an increase for admissions, length of stay, readmissions, and ER visits. The report submitted to the QAC offers frequencies or rates for the utilization data. However, clear goals for the utilization measures were not provided. Without goals or target rates, concerns may not be identified in terms of being over or under a goal.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Recommendation: Include the internal goals or benchmarks in the over and underutilization reports so any areas of concern can be easily identified.
2. The MCO monitors and analyzes utilization data for over- and under-utilization.	X					

VI. DELEGATION

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I. DELEGATION *42 CFR § 438.230 and 42 CFR § 457.1233(b)*						
1. The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions.	X					Policy SC.DCO.001, Delegation Policy, describes requirements and processes for delegation of health plan medical, dental, vision, and behavioral health functions and activities to external entities. The policy:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• Describes oversight processes followed by Delegation Compliance staff. • Addresses conducting exclusion screenings prior to approval of delegation and routinely thereafter. • Addresses execution of written delegation agreements for each delegated entity, and that the written agreements specify the delegated activities, responsibilities of both Humana and the delegated entity, and consequences for failure to fulfill obligations. The South Carolina Subcontractor Boilerplate document defines terminology and includes information about administrative requirements, laws, records and oversight, safeguarding information, member billing, payment, etc. The SC Medicaid Delegation Services Addendum defines related terminology and provides specific information about delegate obligations, auditing and oversight, sub-delegation, etc. Attachments are specific to the activities being delegated and include information about delegate obligations, sub-delegation, reporting, monitoring and oversight, and consequences of substandard or noncompliant performance. Policy SC.CDT.001, Credentialing, Recredentialing, and Ongoing Sanction Monitoring, addresses requirements for delegation of credentialing activities, and includes:

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						• That a pre-delegation assessment is conducted, and credentialing delegates must comply with SCDHHS and NCQA credentialing and recredentialing requirements. • That a delegation agreement is executed with approved delegation entities. • Information about sub-delegation of activities.
2. The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions.	X					Policy SC.DCO.001, Delegation Policy, and Policy SC.CDT.001, Credentialing, Recredentialing, address requirements for annual delegation audits of all delegated entities to assess their continued ability comply with performance standards and requirements. Corporate Delegation Compliance staff conduct annual delegation audits of policies, procedures, and other program documentation, any sub-delegation agreements, entity accreditations, file audits, etc. Standardized audit tools are used for the annual oversight activities. At completion of the annual audit, a score is determined. Any follow-up activities are initiated when the scores are below established thresholds and may include referral to appropriate committees and leadership, corrective actions, termination of delegation, etc. In addition to annual

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						audits, ongoing monitoring is conducted through periodic reporting and meetings. Oversight documentation submitted for review confirmed timely annual oversight for all applicable delegates, and routine reporting and meetings for all delegates. Annual oversight documentation reflected issuance of appropriate recommendations and corrective actions as needed, and follow-up of corrective actions.

VII. STATE-MANDATED SERVICES

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
V I I. STATE-MANDATED SERVICES *42 CFR Part 441, Subpart B*						
1. The MCO tracks provider compliance with:						
1.1 administering required immunizations;	X					Policy SC.QLT.005, Early and Periodic Screening, Diagnostic and Treatment Program (EPSDT), lists EPSDT services and describes member education

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						processes related to EPSDT services. The policy states that Humana identifies members who have gaps in care by running a report for member outreach. The policy also addresses provider education about EPSDT services through the Provider Manual and newsletters, and states the education includes relevant quality performance measures related to EPSDT services. Provider performance is monitored and tracked through population health dashboards and UM reporting. Performance metrics are presented and reviewed in the QAC annually. Onsite discussion revealed that claims and encounter data are used to develop the dashboards and the Stars Quality Report. The dashboards are available to providers via secured login and present member-specific gaps.
1.2 performing EPSDTs/Well Care.	X					
2. Core benefits provided by the MCO include all those specified by the contract.	X					
3. The MCO addresses deficiencies identified in previous independent external quality reviews.			X			During the previous EQR, there were 16 standards scored as “Partially Met” and 8 standards that received a “Not Met” score. Following the 2022 EQR, Humana submitted a Quality Improvement Plan to address the deficiencies. CCME reviewed and accepted the Quality Improvement Plan on June 28, 2022.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						During the current EQR, CCME assessed the degree to which the health plan implemented the actions to address these deficiencies and found the Quality Improvement Plans were not implemented for the deficiencies related to: • References to the New Provider Orientation Checklist in the Provider Orientation and Annual Training policy. Humana has confirmed in both 2022 and 2023 that this checklist is not used. • Lack of a variety of participating network providers as members of the committee responsible for the Quality Improvement activities. Humana's Quality Assurance Committee did not contain a variety of participating network providers. For this EQR, one network practitioner and one physician consultant not participating in Humana's network had been added. • Several appeal resolution letters did not indicate the decision to uphold the original denial was made by a physician with the clinical expertise in treating the member's condition. The letters stated, "a specialist in the Grievance and Appeal Department hereby denies your plan appeal." Additionally, in several appeal resolution letters the verbiage used to describe why the denial was upheld appeared to be above the 6th grade reading level.

STANDARD	SCORE					COMMENTS
	Met	Partially Met	Not Met	Not Applicable	Not Evaluated	
						Quality Improvement Plan: Develop a plan of action to address and correct the deficiencies identified during this and previous EQRs. Include a monitoring component to ensure the plans are implemented timely and all deficiencies are corrected.